Is time of the essence? Experiential accounts from clients of time-limited existential therapy at an HIV counselling service.

Counselling Psychology Doctoral Thesis

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Abstract

This was an idiographic investigation capturing the first-hand experiential accounts of four participants who had recently received existential time-limited therapy (ETLT) at a counselling service for people affected by HIV. To date there has been little research of ETLT practice which is particularly notable since major service providers are increasingly offering only time-limited contracts, reflective of pervasive resource constraints. Further, this research was conducted at a time when we are witnessing the increasing homogenisation of counselling psychology; a profession characterised by an embrace of pluralism. As such, the research aim was to further develop our knowledge of ETLT and so also understand what, if anything, it can contribute to the wider counselling psychology discipline. I conducted two semi-structured interviews with four participants, all of whom had completed twelve weeks of ETLT. First interviews were conducted immediately after the therapy ended and the subsequent follow-up interviews twelve weeks later. The data was analysed using Interpretative Phenomenological Analysis (Smith, 1996), a method which facilitates a hermeneutic phenomenological inquiry into the unique individual experience as well as commonalities between participants. Main themes reflected presenting issues and objectives; how the ETLT was actually experienced; and therapeutic outcomes. All approached therapy reporting a profound sense of isolation, low self-worth, and general sense of unacceptability. ETLT was experienced as an actively relational, affirming and enabling approach and was reported as being highly attuned to participant needs and objectives. Pivotal to this was the client-practitioner relationship and the associated development of a trusting collaborative alliance. Also important was the time-limited setting itself which was shown to instil energy and pace to sessions as well as encourage client responsibility for their ongoing personal process. For these reasons, the primary contribution to our field from this research is that ETLT has been shown to be especially effective and viable therapy option for attending to profound relational unease and engendering a more purposeful engagement with life.

Key words: *Existential time-limited therapy; existential therapy; counselling psychology; sexual minority counselling; HIV counselling; relational, pluralism*.

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Contents

Conventions

Abbreviations:

BPS	British Psychological Society
CoP	Counselling Psychology
ET	Existential Therapy
ETLT	Existential Time-Limited Therapy
HCS	HIV Counselling Service
HIV	Human Immunodeficiency Virus
IPA	Interpretative Phenomenological Analysis
LGB	Lesbian, gay, and bisexual.

Transcript Notations:

…	Significant pause
[ ]	Additional material for context or a real name omitted to safeguard anonymity

Notes:

1. When referring to the endeavour of therapeutic practice, I have largely used the terms '*counselling*', '*psychotherapy*', and '*therapy*' and '*counselling psychology*' interchangeably. Where I make any distinction, I make this explicit (i.e. when specifically describing the CoP discipline).

2. Use of the terms '*gay*' and '*gay man/men'* in reference to the project participants reflects how they identified themselves/their sexuality during the interviews. As such these terms will be used when referring to same-sex encounters/relationships in my data analysis.

3. I have written principally in the first person throughout reflecting my acknowledgement of the subjective nature of my research (an approach supported in qualitative method literature, e.g. Banister et al., 1994; Forester, 2010).

1. Introduction

This project is an investigation of the unique experiences of, and commonalities between, four users of a counselling service (hereafter referred to as HCS) at a well-established sexual health charity in the United Kingdom. Research of existential practice generally, and in particular existential time-limited therapy (ETLT) is sparse with the seminal text from Strasser and Strasser (1997) continuing to be the only major contribution. This lack of research is especially notable when considered alongside the mass '*evidence-base*' for cognitive therapies and other empirically supported approaches (Cooper, 2008, 2011). It can largely be explained by the existential approach being philosophically opposed to the objectivist paradigm that dominates and influences policy for inclusion by major service providers such as the National Health Service in the United Kingdom.

Despite an increased interest in qualitative research in the past decade, reflecting an embrace of postmodernism (Langdridge, 2007a; Manafi, 2010; Smith, 2008), there is now an increasing homogenisation within counselling psychology (CoP), running counter to its core principles of plurality and subjectivity. For some influential commentators this constitutes a crisis for the profession's identity and survival as a distinct discipline (e.g. Deurzen, 2010; Woolfe, 2012). This can in part be explained by the current economic climate of austerity and scarce financial resources since therapy services are far from immune from the demands to justify their existence in terms of effectiveness and value for money. Indeed the former point of proof effectiveness is an explicit criteria set by the National Institute for Health and Clinical Excellence (NICE) for determining which psychological therapies should be provided by the National Health Service in the UK (Guy et al., 2012). By adopting a medical model understanding of issues of mental health, therapeutic orientations that do not concur with this position - including existential therapy - have been largely excluded from its' recommendations for service provision (Mollon, 2010).

A further result of this socio-political and economic climate is that the vast majority of service providers today adhere to a time-limited framework, mindful of the resource constraints. Therefore, conducting research in ETLT - an area that has a sparse existing literature base - and that epistemologically reflects the philosophical roots and values of counselling psychology, seems both pertinent and timely.

At the time of commencing this research, I had worked for three years as a volunteer counsellor with HCS which provides time-limited therapy principally (but not exclusively) to people affected by the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs); as well as people who are experiencing emotional difficulties associated with their sexuality. Generally, HCS Service users are gay men with an HIV positive diagnosis or who consider themselves to be at risk of infection. The service offers principally humanistic, existential or integrative time-limited therapy, reflective of most of their practitioners being recruited from psychotherapy and counselling psychology training institutions specialising in these orientations. As such, a number of the therapists at the service provide ETLT to the clients referred to them and so it is from here I sourced my research participants.

It was my personal experience as an existential therapist in this setting that by making explicit the existential concept of temporality (e.g. Heidegger, 1962) within a time-limited setting and contemplating the potential parallels with our finite existence, a powerful lever for exploration was afforded. As such I approached this project already holding quite an established opinion about the topic I was researching. Therefore, it was extremely important for me to be mindful of this and to remain reflexive throughout the research process, which is something I aim to convey throughout this paper.

Clients of HCS are requested to complete *CORE 5-OM* (Evans et al., 2000) questionnaires at the start and end of their contracts (see *Note1 at foot of this section for an explanatory outline of CORE 5-OM*). The data from these '*outcome measures*' are collated and reported to funding bodies as the supporting evidence for the efficacy and viability of the service provision. One problem with such measurement tools can be, as Stiles et al. (2006) argued, that clients typically score themselves as having improved, or as at least feeling '*less distressed*' at the

end of therapy, compared to when they started. This is not to say that something positive may well have occurred for the client, nor indeed to infer a wider point that such measurement tools do not have value. However, I suggest what we cannot claim to deduce from such standardised data gathering is that any such reported improvement is *because* of the therapy since this does not tell us what actually was *experienced* by the client in the therapy. In other words, from such quantitative measurements we cannot readily claim an understanding of the actual unique experience of the individual, which as counselling psychologists in a profession defined by its' embrace of subjectivity, is what we are most concerned with.

Therefore, as well as identifying a legitimate gap in our knowledge-base of the existential time-limited approach and in particular from the perspective of clients; where there are measurements of '*effectiveness*' the tendency is for standardised quantifiable data from which to report to interested stakeholders, as is the case with HCS. It is these gaps and limitations that constitute the rationale for the current research. As such, this investigation seeks to explore what has been pivotal for four participants, as recent service users in the particular setting of an HIV counselling agency, in their experience of ETLT.

Epistemologically I approached this study from the same vantage point that informs my practice, namely existential phenomenology. It is my view that to understand and make sense of an experience, and one's uniquely subjective engagement with it, is best achieved by a process of description and clarification as first defined by Husserl ([1913] 1931, [1931] 1967). However, in doing so I concur with the hermeneutic position, proposed foremost by Heidegger ([1927] 1962) and Gadamer ([1975] 1996); that one is inevitably and unavoidably engaged in an interpretative, meaning-making process informed by one's subjective lived experience. As the researcher I come to the encounter holding my own preconceived world views which are informed by my lived experience. Therefore, I am equally and inevitably engaged in an associated interpretative process of my participant's interpretative process; which Giddens (1976) was first to term as the '*double hermeneutic'.*

For the actual research, each participant attended two semi-structured interviews in which they were asked to reflect upon their recent ETLT experience at HCS. The first interviews were conducted at the point of the therapy ending and the second, follow-up interviews, were conducted twelve weeks later for the purpose of clarification and further reflection of therapeutic outcomes. To analyse the data, I utilized Interpretative Phenomenological Analysis (Smith, 1996; Smith et al. 2009), a research method which acknowledges and facilitates a hermeneutic phenomenological inquiry. While there is no intention of generalizing any findings to the wider population, this idiographic investigation report is intended to contribute to our understanding of existential time-limited therapy in practice.

In the following chapters I turn first to an overview of the associated existing literature by way of further explaining the rationale for the current research. I then provide an in-depth review of the research methodology used, in terms of definition and epistemological grounding. Specifically, I will outline why IPA was used as well as a detailed rationale for my decision to conduct follow-up interviews. I then present the pivotal Findings chapter and subsequent Discussion. Finally, I conclude by summing-up the clinical relevance and implications of this research, as well as an appraisal of the strengths and limitations of this project and my suggestions for future research.

Note1: Comprising of thirty-four statements about current states of mood or feelings, clients are asked to rate their own against each statement. Scores for each of the items on the questionnaire can be tallied and averaged within and between clients. The extent to which the client's responses differ between the assessment and final session are considered a measurement of the efficacy of the counselling provided. Positive changes in the outcome measurements indicate a successful counselling provision.

2. Literature Review

Prior to conducting the current study, I researched the existing literature in the field to first establish if there was indeed value in further exploring this area of interest and specifically if a worthwhile contribution could be made to our current knowledge-base. Predominantly I sourced my information at the British Library in London utilising the comprehensive on-site and online resources there as well as accessing *EBSCO* via the BPS members' website for journal articles and book reviews. Before reporting upon this review, I explain first the reasoning behind what I identified as the key areas upon which to focus.

Scope of the existing literature review

Mindful of the breadth of associated literature and the word-count limitations, it was necessary to decide what should lie within and what should fall outside of the review scope. This constraint was not considered to be problematic but rather has facilitated what I hope to be a focused and informative analysis of the existing knowledge that is most relevant to the current study. As outlined in the Introduction, this research is based upon the self-reported reflections of recipients of ETLT at an HIV counselling service. Therefore, for the purpose of conveying how the rationale for this research developed and emerged, the Literature Review will focus upon four inter-related areas.

First, I offer an overview of the relatively recent origins of CoP as an applied and pluralistic profession including positioning existentialism within this. As part of this, I examine the context which informs - and in some ways inhibits - the disciplines' key principles today, with fundamental implications for both research and practice. I then turn my focus to a review of the existing process research including exploring what is meant by '*evidence-based*' research. How this has been used for determining the efficacy of therapy in general, as well as in promoting specific orientations over others, will be discussed. Thirdly, since a key aspect of the current research is offering an insight of ET in practice, I offer a review of the principle

tenets of the underpinning theory as well as an existential understanding of how we experience time given the particular setting being investigated here.

I do not promise nor intend an exhaustive analysis of the vast existential literature but do seek to provide a detailed overview of the fundamental principles and main theoretical contributions which define the orientation. Equally so, by recognising and embracing the pluralistic nature of CoP, I do not seek to propose that an existential-informed practice is somehow superior to any other modality. Where I do draw any comparisons and distinctions with other approaches, it is done solely with the intention of further illuminating these definitions.

In the fourth section, I focus upon the current literature for time-limited therapies including consideration of the sparseness of research for ETLT. As stated at the beginning of this section, I consider each of these four main areas of review to be inter-related and together directly relevant to conveying and supporting the rationale for the current study. Further, and retrospective to my initial review, based upon emergent themes in the particular setting the research was conducted in, I also evaluate the existential and CoP understanding of sexuality and working with sexual minorities. This is intended to facilitate a subsequent discussion of the research findings.

2.1 Contextualising Counselling Psychology

CoP has been defined as having six key characteristics (Cooper, 2009): an emphasis on subjectivity; an acknowledgement of the uniqueness of the individual; a collaborative and egalitarian understanding of the therapeutic relationship; understanding the client and ourselves as always relationally embedded; an intention of client empowerment; and finally, a focus on wellbeing and the realization of potential. In the following sections I will explore in detail these attributes and contextualise what is still, relatively speaking, a young profession in the United Kingdom.

While formally recognised by the BPS as a distinct discipline in 1989, it was not until 1994 that CoP was granted full divisional status. Compare this with clinical psychology, for example,

which has been fully established since 1966. Indeed, the five-year delay between recognition and membership was because of resistance from the 'mainstream' BPS divisions, most notably clinical, who challenged CoP's emphasis on continuing personal development and reflective practice, as well as the importance of personal therapy (Woolfe, 2012). In fact it is these very reasons for that resistance that both define and distinguish CoP – and with fundamental implications for both practice and research. Specifically, by embracing subjectivity (Duffy, 1990) and a collaborative and relational approach to the work of understanding clients' problems with living and wellbeing (Milton, 2010), the unique and holistic experience of the individual is granted precedence and so finally afforded due recognition. Reflective of this, in recent years the appetite for qualitative research and first-hand experiential accounts has gained momentum (Smith, 2008).

Nonetheless, several influential commentators from within the profession (e.g. Deurzen, 2010; Cooper, 2011; Woolfe, 2012) have warned that CoP in the United Kingdom faces what essentially amounts to an existential crisis. In a political and economic climate that insists upon proof of efficacy and value for money, CoP is confronted with the real and present risk of losing sight of the very attributes that characterise and distinguish our field in the face of an inexorable demand for Empirically Supported Treatments (EST) and Evidence-Based Practice (EBP) (Miller, 2006; Woolfe, 2012). To sufficiently understand these implications, a review of the historical and philosophical foundations of CoP as well as these associated tensions will be examined in the following sections, including an exploration of what the research '*evidence*' tell us. First, however, it makes sense to expand upon the attributes that characterise CoP as a profession.

2.1.1 An inherently pluralistic discipline

Counselling psychology is unequivocally pluralistic in nature and resists any meta-narrative, meaning that no singular orientation within the discipline should be considered superior to the alternatives. This plurality is evidenced by both the BPS and the Health and Care Professions Council (HCPC) recognising the three main traditions of psychoanalytic-psychodynamic, cognitive-behavioural and existential-phenomenological (including

humanistic) approaches (Orlans & Scoyoc, 2008; Strawbridge & Woolfe, 2010). Rather than being driven by any intention to annihilate the opposition as it were, these recognised orientations should instead comfortably co-exist in a spirit of learning and mutual respect. Kasket (2012: p.65) captures this fundamental aspect when she describes the discipline as follows:

> '*a particularly honest, realistic, pluralistically orientated member of the family of applied psychologies, in that it is willing to expand its horizons to accommodate a plurality of viewpoints, a multitude of possibilities, and an infinite variety of potential 'truths'. Our world is unimaginably diverse, our experience is full of paradoxes, and our selves are multifaceted...Much is unknown and never will be known. Very little can be reduced to bare fact or absolute certainty...I would argue that counselling psychology is the applied psychology that most fully embraces working with these complexities*.'

A salient point here is that counselling psychologists, informed by existential and social constructionist ideas, hold the position that there is no unitary or immutable truth in the experience of living and instead accept that there can be as many possibilities as there are perspectives. Further, the therapeutic work is considered to be much more than the application of standardised treatment protocols (Strawbridge and Woolfe, 2010) with instead the practitioner acknowledging and embracing uncertainty and flexibility. This does not imply futility or that '*anything goes*' in terms of applied practice, nor that such protocols cannot hold much value potential for the client. However, it does mean that we must resist assuming that we can know with utter conviction the answers in a world replete with different experiences and views. Rather, as professionals engaged in research and practice, the aim is '*to maintain open and enquiring minds and a degree of humility in the face of complexity*' (Strawbridge & Woolfe, 2010: p.19).

Within this pluralism, there is an underpinning humanistic and existential-phenomenological philosophy that informs CoP's holistic view of what it means to be human and what a well-lived life might look like. Put simply, the intention is to understand the client in a way that acknowledges them in all their contexts – personal, social, political, historical - that together constitute the lived experience. To do so requires contemplating the person and their

experiences from the position that all that they do is fundamentally relational, both in being with others and with the environment (Milton, 2010). This is a key concept and so is explored further in the following section.

2.1.2 A relational approach to problems with living

As already mentioned, at the core of CoP practice is the endeavour to understand the client's holistic experience of being in the world and how their current way of being might be impeding a well-lived life. Fundamental to this is a view of humans as being inescapably imbedded in the world that we inhabit and as being always in-relation to others (Merleau-Ponty, 1962; Spinelli, 2005; Milton, 2010). This is reflected in the guidelines for professional practice which acknowledge that presenting problems must be considered against all aspects of the client's lived experience. Specifically, they state that the practitioner's role is to '*consider all contexts that might affect a client's experience and incorporate it into the assessment process, formulation and planned intervention*' (BPS Division of Counselling Psychology, 2005: p.7).

In recognising that as relational beings clients are affected by how they respond to and engage with their everyday world, by definition this will include their experience of therapy. For practitioners who are also of course relational beings in the world, this positions the therapeutic relationship at the vanguard of their practice (Division of Counselling Psychology, 2005), since it offers us a real-time experience of the client's way of being with others (Carroll & Tholstrup, 2001; McGinley, 2006; Spinelli, 2005). As Manafi (2010: p.30) argued, this requires the practitioner to immerse themselves in a dialogical exploration in which the aim is to reveal a comprehensive and, crucially, a relational perspective of the client's milieu: '*Understanding the subject as a relation requires us to 'zoom out' so that the wider context becomes more apparent. Human beings are to be understood in the context of a relational totality that connects them to other beings and to Being itself*' (capitalised by the author, in line with existential writers, to distinguish and emphasise 'Being' as existence). Therefore, relating does not stop with other people but also involves our relationship to the surrounding

environment, the physical world, and this is an aspect that is increasingly acknowledged as being vital to understanding the crises that can emerge in life (Milton, 2010; Uzzell, 2008).

We do not function detached from the world since we are irrevocably embedded in it and so how our environment is can have a direct and significant impact on our health and wellbeing. There is an obvious biological reality to this argument in that we physically cannot exist without its resources – for one we breathe, drink and eat (Deurzen, 2010). However, there is also a significant psychological aspect supported by influential studies on the correlation between proximity to the natural environment and wellbeing that have shown, for instance, how readily available contact with nature can substantively reduce levels of stress and associated physiological indicators (Sustainable Development Commission, 2008).

That said and despite the increasing weight of supporting research, Milton (2010: p.298) points to a persistent refusal to acknowledge such a relationship in mainstream psychology. He notes that '*an anthropocentric bias remains in much psychological thinking. Many psychologists have 'stopped' at the boundary of the human body/personality (Higley and Milton, 2008)*'. Indeed, the propensity by many in psychology to continue to '*stop at the boundary*' as Higley and Milton argue can largely be explained by a persisting adherence to an omnipotent philosophical tradition most typically referred to as the Cartesian paradigm. This is characterised by an assumed dichotomy of mind and body, and an assumption that each of us stands distinct from the world and others as rational and autonomous entities (Dilman, 1993).

Such a tendency to dichotomise and limit the parameters of the human experience brings to the fore the philosophical tension that underpins the crisis that CoP faces today, as identified by Deurzen (2010) and Woolfe (2012) among others. Specifically, this tension reflects the continuing and expanding dominance in the Western world of an objectivist paradigm that has shaped not only the fantastic advances in the natural sciences but also dictates how many theorists and researchers work to explain human behaviour and the lived experience. The difficulty for CoP is that this paradigm runs counter to our philosophical underpinnings and values and as such positions the profession in an uncomfortable and vulnerable position. In

the following section this philosophical grounding and how it fundamentally contrasts with that of the mainstream will be considered ahead of making explicit the very important implications for research and practice.

2.1.3 The philosophical context and tensions

As well as being rooted in the counselling profession, counselling psychology is of course also embedded in the realm of psychology and so effectively forms a fusion of two distinct disciplines. The former is first and foremost interested in engaging with the subjective experience, values and beliefs, with an emphasis on the free will of the individual. It is informed by humanistic, existential-phenomenological, systemic, narrative and social constructionist ideas (Spinelli; 2005; Orlans & Von Soyoc, 2009; Manafi, 2010; Shorrock, 2011). Meanwhile psychology is predominantly an applied and experimental behavioural science, and has positivist philosophical roots firmly aligned with the natural sciences (Strawbridge and Woolfe, 2010).

While the philosophical roots of counselling can in part be traced back to the European Romantic Movement of the late eighteenth century (Orlans & Von Soyoc, 2009), it was in post-war United States that it emerged as a discipline. The term itself was coined by Rogers (1951), the founder of the person-centred approach. His key principles of *empathy*, *acceptance* and *congruence* persist today as defining features across most counselling approaches. Other seminal influences from this humanist tradition included Maslow (1968) who popularized the concept of *self-actualisation*, and Perls' (1973) Gestalt therapy that focused upon the holistic experience of the individual at a particular moment in time. All approaches are underpinned by a subjectivist stance that covets the unique experience of the client.

However it is in fact with Kierkegaard ([1844] 1944), the Danish nineteenth century philosopher, theologian, social critic and for many the founder of existentialism that we can see the origins of this subjectivity (Langdridge, 2007a). For him, there can be no singular truth to explain the lived experience and to try to uncover one as a means to securing meaningful living is unequivocally a futile act. His stance is endorsed by another seminal existential

thinker, Nietzsche ([1883] 1962: p.83), who in the same vein asserted that in describing our experience, there are no absolute facts since words '*are but symbols for the relations of things to one another and to us; nowhere do they touch upon absolute truth*'. What we have instead is the uniquely human potential to create meaning – meaning that can never be objective or value-free. And so it is only in subjectivity that the potential to explore purposeful living resides. This is far from an easy option, however, since it requires the confronting of fundamental existential concepts such as the harshness of freedom, responsibility and choice, and invites us to stand apart from the collective rather than lose oneself in the seductive comfort of the masses and conformity. The fundamental point here is that truth is subjective since it is shaped by context and the unique perspective of the individual and so by definition truth can never be unitary.

This is at the core of what is known as *postmodernism* and challenges conventional assumptions of how we reach understanding. This posits that the individual's unique perspective is formed and expressed within a relational matrix that is shaped by the social, historical, political, technological and economical contexts within which their lived experience occurs (Fox et al., 2009; Kvale, 1992). As Manafi (2010: p.27) argues, truth '*cannot be disconnected from the interests, intentions and desires of the speaker. It is an anti-representationalist and anti-essentialist stance which glorifies subjectivity without eradicating respect for the other and the relational systems that sustain us*'. CoP is firmly rooted within this philosophical tradition, reflected by the veneration of the first person experiential account of being. It thereby firmly rejects any objectification of the human condition that assumes separateness.

The embrace of this postmodernism is therefore especially notable both in terms of the philosophical challenge to a positivist paradigm and specifically in how its influence has increased, readily evidenced by the '*explosion of interest*' (Smith, 2008: p.1) that we have seen in qualitative research over the past decade. Nonetheless, one must caution against any false new dawn for the celebrants of subjectivism since, as explained at the outset and indeed a key underpinning for the rationale for this project, influential commentators refer to a crisis

today for the profession (Deurzen, 2010; Woolfe, 2012). This crisis can be explained by the philosophical tension from being at once firmly in opposition to but at the same time constrained and shaped by a positivist paradigm.

First defined by the French philosopher Renè Descartes (1596 - 1650) and typically referred to as the Cartesian paradigm, it has essentially shaped Western thought and attitudes to the generation of knowledge ever since. It has not only dominated all natural science research but also that of applied psychology in terms of both research and practice (Heath, 2002). The epistemological aim for research is to achieve an objective and replicable method in which we can uncover verifiable facts and universal truths about ourselves and the world we inhabit (Papineau, 2002). While undoubtedly being of truly immeasurable worth in particular for the advances of medicine and technology, such a stance being adopted when endeavouring to understand human behaviour from a relational and subjective vantage point, as counselling psychologists do, is challenged as being fundamentally incongruent (e.g. Bohart, 2005; Elkins, 2007; Morrall, 2008; Corrie, 2010; Rapley, Moncrieff & Dillon, 2011).

Problems with living are basically understood as being synonymous with physical illness, and as such the associated epistemology is typically referred to as the *medical model* (Szasz, 1974; Boyle, 1990; Wampold, 2001; Bentall, 2004). It is an approach that assumes emotional suffering to be symptomatic of abnormality or disorder and that should be treated as though one would a physical disease; with the explicit intention of eradicating the symptoms and for the person to be 'cured'. Perhaps the most vociferous critic of this medical model, Thomas Szasz, in his seminal critique of psychiatry, *The Myth of Mental Illness,* argued that so-called '*mental illnesses*' were no more than names assigned to behaviours that were deemed inappropriate or unwanted by society. He considered them to be problems with living dressed-up to be synonymous with physical disease despite no such etiology to support it (Szasz, 1974).

We need only look at both the World Health Organization's International Classification of Diseases manual, now in its' tenth edition (ICD-10) and indeed the seminal American Psychiatric Association's Diagnostic and Statistical Manual (DSM) series, as evidence of the

reach and dominance of this position (Manafi, 2010; Kinderman, 2013). Incidentally, in the recently released DSM-V (2013), yet more problems are categorised as candidates for psychiatric intervention including grief becoming associated with 'major depressive disorder' and the criteria for a 'generalised anxiety disorder' diagnosis being significantly relaxed. Therefore some of the inevitable struggles that will visit most of us in life are deemed suitable for psychiatric intervention. The effect can be to lose sight of pertinent aspects of the person's experience as Kinderman ('*Grief and anxiety are not mental illnesses'*, 2013), notably a past chair of the BPS Division of *Clinical* Psychology explains: '*diagnosis and the language of biological illness obscure the causal role of factors such as abuse, poverty and social deprivation. The result is often further stigma, discrimination and social exclusion*'.

Nonetheless, it is the paradigm of our time and shapes the parameters for that which constitute the mainstream opinion as well as respected and influential research; and so service provision. The enduring reach and omnipotence is readily evidenced by a review of the vast majority of current research journals such as the *British Journal of Psychology*, *Clinical Psychology* and *Developmental Psychology*. From a CoP perspective, the medical model dominance is equally made apparent by our inclusion on the Health Care Professions Council practitioners register (www.hpc-uk.org). CoP is thus presented to the public as being in the business of health-care, pain alleviation and cures.

The influence of the Cartesian paradigm is also reflected in the dichotomy that persists within a profession that is defined by relational practice but that is also required to produce rigorous scientific research. The latter of which the BPS makes explicit by calling for '*the scientific demand for rigorous empirical enquiry*' (Division of Counselling Psychology, 2005, p. 1) to be satisfied. As a result, this leads to counselling psychologists most commonly being classified as *scientist-practitioners* (Strawbridge & Woolfe, 2010) to highlight the dual functions of the role. Lane & Corrie (2006) however, argue that this demand for scientific rigour is being somewhat reframed to incorporate the emboldened position of qualitative research and Strawbridge & Woolfe (2010) have suggested inverting the term to *practitioner-scientist* in order to afford due recognition to the importance of one's practice to the associated

contribution to knowledge. More recently, Woolfe (2012) has proposed instead the idiom *reflective practitioner* in order to accentuate the requirement for reflexivity from the counselling psychologist who is, like his client, relationally imbedded in the same contextual world and so notably removing the term '*scientist*' altogether.

Nonetheless, CoP resides in a society that remains enamoured with measurability and is so fundamentally shaped by a Cartesian understanding of humankind. As Manafi (2010: p.25) claims '*Despite the pluralistic shift within our field, Descartes' ghost still haunts us; his unworldly philosophy continues to influence our conceptualisation of the human self and our practice*'. In other words, there is a stubborn adherence in mainstream psychology and beyond to understanding and framing the human predicament within the Cartesian duality perspective: the mind/body, normal/abnormal, self/other dichotomies discussed earlier. It seems that with the evermore elevated emphasis on providing justification for the spending of all too scant resources in today's economic climate, the tendency to look towards that which can be supported by quantitative research and outcome measurements risks drowning-out the voice of the individual and their lived experience in a sea of disorder manuals and treatment strategies.

By acknowledging and understanding these philosophical, socio-political and historical contexts, and the associated tensions; the significant ramifications for CoP and the crisis that the profession currently faces can be appreciated. Indeed it is I hope also evident that this has particular relevance to the current research rationale. Certainly there are profound implications for CoP from the drive for standardization and homogenisation of evidence-based practice, which I now turn to in the following section.

2.1.4 Implications for counselling psychology research

As I have sought to highlight so far in this review, counselling psychologists approach emotional suffering from a holistic, contextual and inter-relational perspective in which the subjective account of the client is deemed pivotal. Commentators have cited an embrace of postmodernism particularly over the past decade, firmly aligning the profession with its' philosophical roots. This positions CoP as essentially anti-establishment in nature since it

represents a questioning, critical attitude towards the mainstream view of it being a scientifically-grounded discipline governed by objectivist 'evidence-based' research (Miller, 2006; Woolfe, 2012). As also mentioned, an associated increased interest in qualitative research that acknowledges this relational matrix and celebrates subjectivity has been observed (Smith, 2008).

Certainly, some key groups have substantively benefited from this upturn, most notably minority groups in society that have until recently been largely ignored. We can see, for example, a growing literature base of qualitative research around LGB psychology (e.g. Brandon, 2011; Flowers et al, 2006; Hicks & Milton, 2010; Milton & Coyle, 2007). For such non-conformists who have often felt excluded even persecuted by prevailing societal attitudes, affording them an opportunity to make sense of their experience and be understood can facilitate a sense of empowerment and acceptance.

However, based upon his interviews with several influential policymakers, Cooper (2011: p.10) argued that where it matters – at the senior levels where the appropriate types of service provision are decided – there is '*no postmodern turn just around the corner'* and predicts that the demand for empirically supported treatments (EST) and evidence-based practice (EBP) will not diminish. Far from it in fact, since he saw '*very little evidence of a shift of interest towards qualitative research: indeed, to a great extent, these colleagues seemed more interested in developing increasingly sophisticated methods of quantitative enquiry'.* Corrie (2010: p.52) argued that this is because '*gold standard evidence is essentially 'product focussed', whereas practitioners are 'person focussed', less concerned with global statements about effectiveness than how information can inform the subtleties of what they do*'. Therefore there is a skewing towards those therapies that have subscribed to developing an empirical justification for inclusion as effective 'treatment' options.

Midgley & Kennedy (2011) point to one consequence of this being that other orientations without such a base, in particular psychodynamic therapy, have been disadvantaged – existential therapy can safely be included in this group since it equally has no such base (Cooper, 2008). Elkins (2007: p.485-6), meanwhile, dismisses the entire concept of EST in

terms of any claims of superior efficacy for any one orientation, arguing instead that '*they are all 'empirically supported' because the evidence shows that they are all effective, and equally so*'. The problem is that despite this, '*it has had no detectable effect on the debate*' since the non-EST research does not command the same respect by those who decide on the viability of approaches.

Certainly, the primacy of EST is most obviously reflected in the gravitas afforded to Randomised Control Trials (RCTs) in research (Elkin, 2007; Cooper, 2011; Frost, 2012). Basically in order to 'prove' one condition, participants are randomly and blindly allocated to this and a comparable 'control' condition. From this any emerging statistically different results are taken as evidence of effectiveness with researchers able to claim they have minimised any risk of bias. As Frost (2012: p.58) points out, '*here the medical model applies itself to counselling with the idea that psychological issues can be specifically diagnosed and specifically treated with specific techniques*'. The key implication is that by identifying methods of treatment that can be rolled-out universally means that for those who value the importance of subjectivity, '*RCTs can be considered the epitome of de-individualising, de-contextualising research methods because of the high levels of experimental control involved*' (Cooper 2011: p.10).

Morrall (2008) sees this debate as a political and financial one since science and research is essentially governed by politicians and medical insurance companies. It is hard to contest that we are in a society that craves predictability and control and perhaps now more than ever demands evidence of efficacy and value for money (Deurzen, 2010; Woolfe, 2012). Only with such 'evidence' is an approach or model deemed to be fit for purpose. This holds much risk for a profession that esteems plurality and subjectivity, something that Deurzen (2010: p.xv-xvi) captured by warning:

> '*what we are witnessing at the moment is a process of one-dimensional professionalization which is more interested in quantitative than qualitative outcomes and favours approaches that can be rolled out across the board, tempting us into the shallows....this short-sighted focus is dangerous...we need to rethink our values and*

commitments as counselling psychologists and be true to the principles on which we founded this profession'

The inference that specific approaches or techniques are of less significance when compared with relational factors also has difficulties from a political perspective. Bohart (2005: p.45). warns of a '*credibility*' issue with policymakers and financial stakeholders by arguing that advocating for an overtly relational, non-technique based therapy '*does not fit the dominant medical model, and if adopted, might lose practitioners credibility in the eyes of third party payers and others that think in [those] terms*'.

This is the crisis for counselling psychology. We are facing the homogenisation of psychological therapies which runs counter to the essence of our profession; the embrace of plurality, subjectivity and an emphasis on the unique inter-relational experience. Kinderman (2009) predicted that within a decade CoP will no longer be recognised as a distinct profession by the BPS or HCPC; and that it will instead be subsumed by clinical psychology since the distinctions between the two are becoming increasingly negligible. Certainly this would seem entirely feasible given the current direction. Therefore, to stand any chance of maintaining a separate identity, we must strive to re-acquaint ourselves with that which defines and characterises counselling psychology, including its rich philosophical underpinnings.

However, to influence policy and so be accessible to NHS service users, for example, therapeutic approaches will struggle to even reach the policymaking table without a substantive body of supporting evidence. A key question which follows from this is can such an evidence-base be achieved from an existential point of view? To a large extent, this depends on how one defines 'evidence'. As has been discussed above, at the core of existentialism is the embrace of subjectivity and the unique lived experience of the individual. It is difficult to see how producing quantitative research that is rooted in objectivism and so adopts traditional scientific research methods can be compatible with this central underpinning (this incompatibility is discussed in more detail in *Chapter 3*, sections *3.1*. and *3.2*). However, what may be an uncomfortable truth for some is that it is this type of research which is considered to be 'evidence' by those who make the decisions on such matters

(Cooper, 2011). I suggest what can be achieved, nonetheless, is a comprehensive *knowledge-base* grounded in qualitative research and aligned with existential phenomenological philosophy, from which quantitative research – that is in turn informed by, and developed from, the former – can then produce the type of evidence policymakers require.

The implications are great - these are not merely epistemological debates of interest to a select few but rather represent a major problem '*that is having a direct impact on the availability of different therapies in the NHS, as well as employment prospects for counsellors and psychotherapists*' (Cooper, 2011: p.10). The fundamental choice presented is do we enter the fold and work within the rules and parameters as they are currently defined, or do we steadfastly defend our core principles and philosophical underpinnings, promoting them from the outside looking in and waiting, hoping, for a paradigm shift?

It is our very embrace of plurality and most crucially, our ethical commitment to promoting the wellbeing of clients, that in fact compel us to work to ensure ET and other non-CBT approaches are included as treatment options. This requires a pragmatic acceptance that in order for these orientations to be considered viable, they must produce the type of evidence needed by those with responsibility for quality service provision. I suggest such a stance does not equate to any wholesale abandoning of the emphasis on qualitative research, nor indeed an unqualified embrace of quantitative methods. However, it does mean engaging and producing relevant research of high quality that helps build our knowledge and from which subsequent studies can build from that fulfil the criteria of policymakers. Ultimately, surely a*ll* research that helps us better understand that which enhances the client's experience or challenges us to consider and re-think what and how we work should be welcomed.

In the following section, I outline what some of the key empirical research has reported. As will be shown and as Cooper (2008) has argued, there is much for the existential approach to be encouraged by, albeit cautiously so.

2.1.5 What does the 'evidence' tell us?

The abundance of research around particular orientations compared with the scarcity or even absence for others tells us only that the former have been researched more than latter. Referring to the work of Watson et al (2003), Cooper (2008: p.38) makes this point by arguing that *'the amount of evidence...should not be confused with evidence of superiority, and experimental studies which have directly compared CBT against other bona fide therapies have generally found them to be about equivalent efficacy'*. Indeed, Timulak (2008) found that practitioners had a tendency to overestimate the significance of technique, and underestimate relational aspects when compared to their clients' perspectives. Perhaps most striking from this particular research, however, was that in only around a third of cases did the practitioner and client agree on what were the critical factors in therapy or what was the most significant session.

Other major research (e.g. Asay & Lambert, 1999; Lambert, 1992; Norcross, 2002; Wampold, 2001) has identified the therapeutic relationship as being *the* most important factor influencing a positive outcome, regardless of orientation (although the definition of what constitutes the 'relationship' varies significantly amongst studies). In 1999, the largest ever review of research upon the therapeutic relationship was commissioned by the American Psychological Association Division of Psychotherapy. This seminal meta-analysis found that the therapeutic relationship made a '*substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment*' (Steering Committee, 2002: p.441). Representing an unequivocal and influential acknowledgement of the centrality of the relationship to clinical outcomes, the report goes on to state that **'***Efforts to promulgate practice guidelines or evidence-based lists of effective psychotherapy without including the therapy relationship are seriously incomplete and potentially misleading on both clinical and empirical grounds***'**.

However, there is also substantial evidence in support of specific therapies as being especially effective for attending to particular issues – for example, and perhaps most obviously cognitive and behavioural therapies (CBT) in the treatment of anxiety and sexual dysfunction

(Ogles et al., 1999). Research based upon outcome measurements and the use of RCTs do lend support to these specific approaches as being more efficacious than others (Chambless, 2002; Hunsley and Di Giulio, 2002). Undoubtedly, this well-established evidence base supporting CBT is reflected in the unquestionable dominant position it holds within major providers such as the NHS.

Of course to a large extent, the researcher's vantage point will determine the questions asked as well as the answers found. Returning to the APA's (Norcross, 2002) report, a key finding was that different modalities were essentially found to be of equivalent efficacy. This has been called *'the dodo bird'* verdict (Cooper, 2008; Luborsky et al., 1975; Rosenzweig, 1936) in reference to the Alice in Wonderland character who decrees that '*everyone has won and so must all have prizes*'. Asay and Lambert (1999), from their extensive meta-analysis reported that just 15% of variance in therapeutic change was attributed to the particular orientation adopted. Meanwhile some 40% of the variance - and the most significant factor - was credited to '*client variables and extratherapeutic events*'. In other words, aspects such as the individual client's circumstances and their level of motivation were identified as being principal contributors to successful outcome. Nonetheless, a sizeable 30% and the second most common factor in influencing positive outcome was the therapeutic relationship; including variables such as empathy and therapist's willingness to offer feedback to their client.

However, these findings have not gone without challenge. For instance, Beutler et al. (2004: p.292) revisited the Lambert (1992) data which Asay & Lambert drew from and, while concluding that '*there can be no doubt that relationship quality is one of the stronger correlates of outcome*'; they calculate that the therapeutic relationship more modestly accounts for between 7% and 17%. Incidentally Beutler et al. as well as Norcross (2002) also make the important point that there will surely be variance between individual clients and their specific presenting issues in terms of how potent a factor the relationship is to their process and outcome.

Nonetheless, and numbers aside, the importance and influence of the relationship to the therapeutic process is widely acknowledged and is reflected in the development of relational

approaches across all orientations (Magnavita, 2000; Cooper, 2004). For example, the intersubjective psychodynamic therapy as proposed by Stolorow et al (1987), dialogical Gestalt therapy (Hycner & Jacobs, 1995), and a relational emphasis to transactional analysis (Hargaden & Sills, 2002) are indicative of this. Further, even when the approach is not considered as overtly relational, the therapeutic relationship has been found to be a fundamental contributor to outcome (Cooper, 2004).

Clarke et al. (2004) found that when asked what they found to be most useful in therapy, clients cited a variety of factors. Some of these were specific to the therapeutic approach they received, while others were non-specific and considered common to all such as being listened to and developing a sense of being more at ease with oneself. Bohart (2005) identified five such common factors: the relationship, the client as self-healer, the extent to which the therapist can instil hope and optimism, the therapist's ability to articulate a '*healing explanation*' for the client, and lastly, the therapist's personality.

Subsequently, Cooper and McLeod (2010) have proposed a pluralistic framework for therapy recognises and accommodates these common factors, while at the same time allowing for orientation-specific techniques and strategies to be utilised. Their model acknowledges the salience of the therapeutic relationship but crucially positions the client as being central to the process and therapy outcome potential. This constitutes a more inclusive approach by allowing practitioners to maintain their theoretical stance by not assuming that there is any singular efficacious approach. At the same time it facilitates a tailored experience for the client based upon need and their preferred method for achieving their objectives. The framework includes an ongoing reviewing and 'checking-in' as the work progresses which is intended to empower the client by positioning them as pivotal to shaping the therapeutic process. Frost (2012: p.60) considers this as representing '*a move back to the humanistic way of thinking, that the client is central, not the theoretical perspective, that the relationship between counsellor and client is fundamental to success in counselling'*. Certainly it positions the client and the therapeutic relationship as central to the process and would seem to provide a pragmatic framework that for one would appear comfortably attuned to the

existential approach and perhaps represents a way forward for counselling psychology as a distinct profession.

Overall, the various findings cited above point to a very substantive empirical evidence-base that positions the therapeutic relationship as a central determinant of client experience and outcome. Crucially, much of the research suggests that this transcends any orientation-specific claims of efficacy. However, what seems substantially less clear is what in particular it is about the relationship that facilitates positive outcome for the client, or how it happens. The same point is made by Cooper (2004: p.457) when he argued that '*(I)n many respects, our understanding of the key components of a facilitative therapeutic relationship have progressed little since Rogers' seminal work on the necessary and sufficient conditions for therapeutic personality change (Rogers, 1957), and it would seem incumbent on us to develop and expand this horizon*'. Indeed understanding how the relationship impacts the overall therapeutic experience is a pivotal component of the rationale for the current research. And as will be shown in the following sections, which describe and evaluate the existential approach, the therapeutic relationship is at the core of ET practice.

2.2 Understanding Existential Therapy

By way of further elucidating the rationale for this project, I provide in this section a review of the seminal literature that has shaped and defined ET. I examine the major theoretical contributions which will perhaps above all show how it is firmly embedded within the realms of counselling psychology as a philosophically-informed approach that celebrates subjectivity, rejects rationalism and objectivity, and adopts an unequivocally relational attitude to Being. Further, and since the focus of the current research is upon ETLT, I end this section with an analysis of an existential understanding of time, an aspect of existence considered fundamental and inseparable to our lived experience. In the subsequent section to this (*2.4*) I will then look specifically at the ETLT as part of a wider review of the associated literature on time-limited settings.

2.2.1 Fundamentals of the existential approach

The existential approach works to address problems with living from a philosophical vantage point that contemplates the client's lived experience within a fundamentally relational matrix. Since we are always relationally-embedded with others and with the world, our difficulties in life must equally be understood from this perspective, taking into account the client's personal, historical and socio-political contexts which collectively inform their values, attitudes and assumptions. Existential therapists do not readily assume painful feelings to be symptomatic of some flawed or disordered thinking that must be remedied or eradicated. Nor are they regarded as pathological in origin; and so in tune with CoP, there is a fundamental rejection of the medical model approach to problems with living and an acknowledgement of our inherent relatedness. Rather, feelings are our *emotional compass*, for they reveal that which matters most to us (Deurzen, 2002). That is, they are instructive of how we are and how we make sense and engage with the world and others.

From such an emphasis on the inter-relational, it perhaps evidently follows that ET positions front and centre the therapeutic relationship in the work since it affords the immediate means of access to the client's way of being, both in the world and with others (McGinley, 2006; Spinelli, 2005). A primary intention of the approach is to reveal the client's current way of engaging with the challenges that they are encountering and this is facilitated by promoting a therapeutic engagement that esteems the subjective first-hand account of the client. It is by engaging in such a process we can find meaning in life from the crises and dilemmas that we face. Acknowledging the possibilities and potential as well as the intrinsic limitations of one's unique lived experience, facilitates a more purposeful, vital and authentic engagement with living (Kierkegaard, 1944; Deurzen, 2002).

While based upon philosophical ideas spanning centuries as is reflected in the vast literature base, the existential approach is predominantly informed by some key European philosophers, most notably Kierkegaard ([1844] 1944), Nietzsche ([1883] 1962), Heidegger ([1927] 1962), Sartre ([1943] 1956), Merleu-Ponty (1962), and Camus (1942). Added to this, there have been important contributions from theorists in the United States, in particular

May (1977; 1983) and Yalom (1980) which also deserve recognition. Collectively their ideas serve to underpin the existential orientation and as such I will expand upon the salient concepts from these contributors below.

Key philosophical ideas that inform the approach:

A central assumption is that we are all governed by universal and immutable aspects of human existence known as *givens*, and which include concepts such as *freedom*, *responsibility*, *choice*, *anxiety, isolation*, *meaninglessness*, *guilt, thrownness, temporality* and *death*. These are the conditions that underpin living and, crucially, cannot be altered although we may well seek to deny or avoid them. When we do, confronting them will evoke existential anxiety since this brings into stark awareness ones' mortality (Boss, 1979; Jaspers, 1951; Tillich, 2000). This anxiety is not to be understood as the fear or neurotic anxiety that can emerge from a perceived threat in our personal everyday lives (May, 1977; Driscoll and Tantam, 1999). Rather, it is the profound and inescapable feeling that comes from a meaningful engagement with life; one in which we become mindful of our limitations and our mortality. In fact our relationship to this anxiety is at the core of existentialism for it is '*the price we pay for freedom'* (Cohn, 1997: p.71) and is our saving grace since it is the conduit for finding meaning over futility.

It was Kierkegaard (1813-55) who first captured the fundamental conflict between the concept of *freedom* afforded by our existence and the associated limitless possibilities, against the certainty of our finitude and impermanence. He draws a fundamental distinction between fear and this existential anxiety, or *angst*. Fear has an object, it is fear of *some* thing and refers to the *ontic* (the actual ways in which we live our everyday lives); while anxiety is a fear of *no* thing - a dread of nothingness as well as of freedom and possibility. It represents the *ontological* given of existence and Kierkegaard (in Lowrie, 1944: p.38) distinguished as so: *'[anxiety] is different from fear and similar concepts which refer to something definite, whereas [anxiety] is the reality of freedom as possibility anterior to possibility'*. Anxiety is considered inevitable in human existence and as such it is neither positive nor negative but simply an essential part of Being: it is '*the giddiness of freedom'* (ibid, p.61).

With his magnum opus *Being and Time* ([1927] 1962), like Kierkegaard before him, Heidegger also distinguished between the *ontic* of everyday living and the *ontological* aspects of human existence as manifested in *Being* and *Being-in-the-world* (hyphenated to emphasise the inter-relational nature and of living). He purposely used the term *Dasein* rather than man or person as a means of highlighting the uniquely human condition of self-awareness and connectedness to the world. Dasein is literally translated to English as '*being there*' although most typically as 'being-in-the-world' (Cohn, 2002).

Heidegger worked from the same paradox of life as Kierkegaard although shifted the emphasis from possibility to the finitude of existence. We are *thrown* into the world without our choosing and then ultimately we are confronted with the certainty of pending death (Heidegger, 1962). These two absolutes of life together represent the *facticity* of existence. It is only in the in-between that we have choice. Indeed we are compelled to make choices which, as well as requiring the rejection of alternatives, will foster uncertain outcomes. One such choice we have is to acknowledge - or deny - the certainty that we are approaching death. If we choose to confront it, the resulting ontological anxiety affords us the potential to live life deliberately and with purpose. If we try to avoid or deny, we are choosing an inauthentic engagement with the world; but the *choice* of inauthenticity is an authentic one. This is Heidegger's '*grundbefindlichkeit*', the fundamental way that we are.

Other key features of Heidegger's Dasein, as well as the *thrown-ness* into the world *(Geworfenheit)* already alluded to above and which all essentially signify facets of human subjectivity include (Heidegger, 1962):

> *temporality* - that is our lived experience of time (this will be explored in detail in section *2.3.3* given its particular significance to the current research)
>
> *mood* - a pre-reflective awareness of the fear of non-Being
>
> *care* - our active concern and engagement in the world
>
> *authenticity* – permeates all existential writings. Evoking Kierkegaard's and Nietzsche notions of subjectivity and the value of non-conformity, when we do not take our

existence and the world we are in for granted or 'hide' in the masses; when we stand apart, we have the means to realise our possibilities and potentials

Sartre ([1943] 1956) conceived human existence to be emptiness (or *nothingness*) since there is no entity of self. Instead this is something that we are forever creating and constructing from our being in the world. He considered there to be multiple layers of consciousness but for the purpose of brevity here, put simply (and akin to Heidegger's *Dasein*) it is not something one has or is but something we continually create in our actions. A sense of self gradually emerges from our lived experiences and the labels we attach to ourselves, but is continually changing, never fixed and forever intangible. This essentially constitutes the *freedom* of being human.

He elaborated on Heidegger's fundamental concept of choice within the confines of facticity. That is, I inherently have the freedom to choose how I am and act in my life and as such I – and I alone – must take *responsibility* for the choices that I make as part of this freedom. These two existential givens – freedom and responsibility – are inter-related since the former evokes the latter. For Sartre (1956: p.439), we are '*condemned to be free*' for even not to choose is a choice. However, electing to not choose represents an act of *self-deception* since it is an attempt to avoid the anxiety that inevitably is generated by the responsibility for freedom. This self-deception is in turn revealed in the roles that we assume as a means of concealing the emptiness of existence and so avoiding the angst that this imbues. Such strategies are nonetheless examples of living in *bad faith* (*mauvaise foi*) because they represent inauthentic ways of being. Sartre argued that we are typically predisposed to such strategies and usually it is only through some life crisis that demands that we, reluctantly, discard these deceptions and confront the raw anxiety of existence.

Camus (1942) argued that such an engagement with life, however, is fundamentally tragic for the very fact that we are conscious; there can be no welcome conclusion. To actively acknowledge the fact that I will die, demands courage (May, 1977; Tillich, 2000) since our underlying awareness of our finitude manifests itself in fear. Tillich (2000: p.39) explained how '*anxiety strives to become fear, as fear can be met by courage*'; in other words, we can

do something about it. Such everyday manifestations of anxiety become then our ontic messengers, inviting us to be courageous enough to confront the realities of our existence (ibid, p.36): '*anxiety turns us towards courage, because the alternative is despair...courage resists despair by taking anxiety into itself*'. The more that we can source the necessary courage and embrace this anxiety, the greater the opportunity for realising potential and finding meaning – a notion first postulated by Kierkegaard ([1844] 1944: p. 139) when he declared that '*the greater the anxiety, the greater the man*'.

May (1977) draws the link with *existential guilt* which is evoked when we deny or try to avoid the given of our finitude. This is because when we deny this we also deny our possibilities and for this we experience guilt. To a degree, since we cannot live constantly in a state of authentic Being, guilt is inevitable and as such is a given of the human condition. If we lock-up our potentialities, we *are* guilty – the same as we *are* anxious (Goldstein, 1940; Boss, 1963). Again, these are not conditions that we have, but rather something that we are. To be anxious is a facet of Being, it is '*an emotional state which does not refer to anything definite...the source of anxiety is nothing and nowhere...it is the inner experience of being faced with nothingness*' (Goldstein, 1940: p.92).

This proposition that we *are* our feelings, and which permeates existential thought is explained by the concept of *embodiment*. Most closely associated with Merleau-Ponty ([1945], 1962), it is central to the existential understanding of the lived experience. He argued that consciousness is essentially understood as being embedded in the body and so it is with our body that we perceive and interact with the world. As such consciousness cannot be contemplated as a distinct entity from which our physical being can be disentangled or separated from.

The more we can face and accept these inescapable constraints of existence; the inter-relational nature of our lived experience; our freedom and responsibility to choose and create meaning for our lives; and confronting the resultant existential anxiety, the more able we are to fulfil our potential. Iacovou (2009: p.272) explains how, by engaging with these philosophical ideas, existential therapists can facilitate a journey of both acceptance and

realising of their potential: '*With the wisdom of philosophy to guide them, they encourage the understanding and acceptance of the existential givens of existence. Through this process, clients become aware of their ability to make choices (within their own limitations and possibilities) and achieve clarity on their personal values and life meanings*'.

The flexibility required by such an emphasis on the subjective lived experience demands the rejection of any theoretical dogma as well as a reluctance to adopt standardised techniques or implement formulaic strategies. Cooper (2003: p.2) explains that '*...at the heart of an existential standpoint is the rejection of grand, all encompassing systems; and a preference for individual and autonomous practices*'. This does not imply eclecticism or an 'anything goes' attitude to therapy. Indeed there are generally accepted aspects that, together with the philosophical emphasis described above, serve to characterise the approach (Deurzen, 2005; Iacovou, 2009) and which can be understood as follows:

A phenomenological method of inquiry

Edmund Husserl ([1931] 1967), philosopher and founder of phenomenology, proposed that in order to truly understand another's first person experiential account we must '*bracket*' our own preconceived assumptions and attitudes towards whatever it is that we are seeking to investigate. This bracketing process he called *epochè* and the essence of this key concept is to doubt that which we would otherwise take for granted in everyday engaging with our world and as such do not necessarily 'see'. Therefore the intention is to bring to our awareness that which can otherwise be concealed in this everyday way of being and so to approach it as though afresh, stripped of preconceptions.

This attempt to transcend our own perspective so as to be able to view as perhaps someone else might requires three aspects which together constitute Husserl's phenomenological (or *eidetic*) reduction method: *description*, *horizontalisation* and *verification*. To summarise this process: the experience is described first-hand in as much detail as possible while the practitioner/researcher actively avoids any interpreting of meaning (description) and during

which no hierarchy of importance is attached to the details of that being presented (horizontalisation). It is an iterative process of uncovering and revealing of the phenomena to ensure as much clarity and understanding as possible is achieved. Only then are *tentative* hypotheses or ideas around meaning developed and checked with the client, or in the case of research by cross-referencing with original transcripts for the purpose of verification.

This means of understanding the lived experience is intended as an alternative - but equally rigorous - approach to that of the natural sciences (McLeod, 2000; Smith, 2008, Willig, 2008). However, the feasibility of epochè and phenomenological reduction as a method was challenged by key existentialists including Heidegger, Gadamer, Sartre and Merleau-Ponty, with the latter deeming it as essentially unattainable: '*the most important lesson which the reduction teaches us is the impossibility of a complete reduction'* (1962, p.xiv). Their core philosophical criticism was that in proposing such a rigorous method of suspending the inherently human attributes of preconceived assumptions and beliefs; rather than being a radical departure from natural science, Husserl was in fact thinking very much within the realms of the Cartesian logic – that things can somehow be separated, variables manipulated (see note below*).

How pure the method can be, in terms of how much we can actually bracket our preconceptions and assumptions continues to be much debated (e.g. Giorgi 2010, 2011; Smith 2010). Nonetheless, its central purpose in terms of seeking to transcend our worldview in order to look afresh at the experience of another's remains a cornerstone of an existential-phenomenological inquiry. Practitioners subscribing to a more existential hermeneutically-informed approach, including myself, are guided by at least an intention to achieve epochè while acknowledging and accepting the limitations of fully realising it (Ashworth, 2003; Langdridge, 2007).

**Note: This challenge signified the hermeneutic turn towards an existential epistemology which I will examine in greater detail in the Methodology section of this paper since it underpins the current research.*

The therapist as co-traveller

The therapist is not assumed to be the expert with some superior insight and answers to a 'right' way (Spinelli, 2005; Deurzen, 2002). Instead the work is a co-creative and collaborative dialogue between client and therapist together exploring and making sense of the former's predicament. ET, as Spinelli (2005: p.151) argues, '*avoids bestowing upon the therapist the role of superior, objective instructor who distinguishes for client those beliefs, attitudes and behaviours that are assumed to be 'irrational' and who attempts to replace them with 'rational' ones*'. The therapeutic relationship is considered egalitarian in nature and by avoiding assuming the role of expert in the room we '*return psychotherapy to its original meaning: the attempt to 'stay with', 'stand beside' or attend to another*'.

As McGinley (2006: p.304) reminds us, an existential understanding of the therapeutic relationship is that *'we ourselves <u>are</u> the relationship'*. In other words, we are inseparable from it since we are always in-relation with the other. This presents a fundamentally different approach to contemplating human distress that rejects any notion of client as separate entity imbued with their problems. Instead their difficulties with living shift to the realm of being in relation to others and to their environment. It is, Manafi (2010: p.26) argues, '*in the space in-between, on the 'bridge' that is an alternative, critical way of thinking that does not eradicate subjectivity but focuses instead on the clarification of human dynamics*'. So it is about shifting the focus to understanding that which goes on between people rather than within. Such a stance is at the core of existential CoP.

Celebrates uniqueness and promotes living life deliberately

Related to the above and again a fundamental characteristic of the approach is the non-prescriptive attitude adopted by practitioners. Existential therapists do not promote a preferred therapeutic outcome based upon prevailing societal attitudes and norms but instead work to uncover for the client the personal meaning and resonance that they can derive from their unique circumstances. Deurzen (2002: p.87) refers to this by explaining that the orientation '*advocates a return to the unfashionable practice of shaping one's life after one's ideals. Not imitation of the socially desirable but aspiration to the ideally valid is seen as*

the motivating force par excellence'. Clients know their capabilities better than the therapist can ever expect to and so the work is about facilitating the clients journey towards a life that is in tune with their values, potential and aspirations; accepting the responsibility for the choices and changes that they can make - and sourcing the courage to take them (Deurzen, 2005).

Rejection of psychopathology

The existential approach diverges from psychiatry and much of mainstream psychology by representing a profoundly different philosophical understanding of the human experience. In rejecting the medical model's understanding of distress, existential therapists instead consider such difficulties with living as being just that – problems encountered as part of the process of living life. As such these do not belong in the realms of medicine and disease (Szasz, 1974) as they can only be appropriately and sufficiently addressed from a holistic perspective that acknowledges relational and contextual factors (Deurzen, 2002). So the principle intention is not to remedy but rather an authentic uncovering of the client's way of being in order to empower them to make informed choices. Of course symptom alleviation and a move towards wellbeing are as much a desirable outcome in ET as any other (Spinelli, 2005) but the key point is that we do not readily approach all human unease or distress as symptoms that must be promptly cured or eliminated. If the message being conveyed in the distress is understood, then valuable meaning and growth can result.

By working to become attuned to the clients' current worldview we help cultivate an environment where a sense of trust and acceptance can flourish. This in turn serves as a conduit through which an open and honest exploration can flow. One in which assumptions and attitudes that have until now gone unchecked can be challenged, confronted and alternatives contemplated, thereby engendering a sense of empowerment and autonomy. In terms of practice, and while there is a reluctance to incorporate uniform strategies or techniques, there is nonetheless a clear framework from which practitioners can utilise to facilitate establishing the holistic world view, and which will be expanded upon in the following section.

2.2.2 A framework for existential practice

A framework for an existential-phenomenological uncovering of the client's subjective worldview was first proposed by Binswanger (1946) who referred to the *physical*, *social* and *private* realms of existence within which we function and relate to the world. These were subsequently expanded upon to include a *spiritual* dimension by Deurzen-Smith (1984, 1988). While this latter aspect had been alluded to previously by Buber (1923), Jaspers (1951) and Tillich (1952), it was Deurzen-Smith who first made it explicit. Specifically, each dimension of existence can be summarised as follows:

> ***Umwelt*** refers to one's attitudes towards the *physical world* in which we reside. These reflections should not be considered insignificant or irrelevant to the therapeutic inquiry but instead informative of the client's wider worldview and upset
>
> The everyday relating and engaging in the *social world* is explained by ***Mitwelt***. Again, what the client tells us about such interacting is informative and should not be ignored or dismissed. Polar opposites such as conformity and rebellion, belonging and isolation, acceptance and rejection and the key intermediate of acknowledgement are found here
>
> ***Eigenwelt*** is the *private dimension* in which our intimate relating with self and others reside. This is clearly a key dimension for exploration in therapy since how we understand such relationships and the meaning we attach to them fundamentally affects one's sense of self in relation to significant others. Poles here include confidence and doubt (of self), integrity and disintegration and with the moderate experience of autonomy
>
> Finally, ***Uberwelt*** refers to the *spiritual dimension*. Not to be confused or confined to religious affiliation, this is about one's relationship to our ideological beliefs about life and death; and how our sense of values are shaped or influenced by something greater than self. It is here that the need for a longer-term purpose and sense of meaning to our lives is derived and attended to. Pole positions here include meaning and meaninglessness, purpose and futility and with an intermediate value of wisdom

By utilising the Husserlian phenomenological method described earlier, the different ways and contexts of how the client engages with the world are revealed. Mapping the experience against these dimensions affords the practitioner a holistic understanding of the client's lived experience. Central to the existential approach is the view that we are always and inevitably immersed in living within these polarities of human existence and the resultant tensions (Deurzen, 2002). In terms of practice, it is therefore about bringing into view these tensions and understanding how the client engages with them. Deurzen cautions that it would be a mistake to favour one polarity over its converse since to ignore the opposing side is a failure to confront the paradox inherent in an authentic engagement with living and being with others.

We cannot expect to reach a holistic understanding of the client's lived experience if we are inclined exclusively to the positive (purpose over futility; belonging over isolation; happiness over sadness) for that is not a true reflection of the full spectrum of being. This is equally pertinent and relevant to the therapeutic relationship which Deurzen (2002: p.70) emphasises by arguing that:

> '*the existential approach disagrees with the assumptions of the humanistic approach which dictates that human relationships ought to be modelled on total acceptance of and empathy for the other person, as this represents only one side of the inevitable polarity. This polarity is one of love and hate, appreciation and resentment, like and dislike. It can only be managed successfully if one is willing to face the paradox of human relationships'*.

As therapists, then, the danger in ignoring or avoiding the 'negative' in our clients or ourselves is that we can serve to construct an inauthentic or false caring situation (Sartre, [1943] 1956) which ultimately does not facilitate an enduring new way of being.

By making the often implicit explicit new possibilities for future living can emerge since, Deurzen (2002: p.62) argues, this *'allows the therapist to facilitate her clients' journey through life and encourage their expansion into new territory rather than restricting and limiting them by assigning them certain qualities and characteristics, which confine them to a set position'*. While particular attention may at times be focused upon one dimension during the therapy

and indeed a client may well want such a focus, for wellbeing to be sufficiently restored problems with living should be contemplated as residing in all four dimensions. To further elucidate the role of the existential therapist in this process, Deurzen draws an analogy with an art teacher who draws her student's attention to a shadow on a painting that the student has until now overlooked. Equally so the therapist should endeavour to draw his client's attention to assumptions that have until now not been recognised or their significance not fully acknowledged.

Spinelli (1994; 1997; 2005) proposed a similar framework of four *realms* for existential practice, but which is perhaps most notable for its explicit emphasis on the inter-relational nature of the therapeutic encounter. Each realm is concerned with the message that the client takes from their relational experience – of themselves (the *I-focused realm*); of the therapist (the *you-focused*); and then both being together in their therapeutic encounter (the *we-focused*). All three of which are considered and examined for the purpose of then ultimately inquiring beyond to their relationships elsewhere, the *they-focused realm*.

To summarise this exploration of the existential approach so far: it is an orientation that celebrates subjectivity and views the human condition as being forever in-relation to others and the world - and so thereby attuned to and informing the CoP's philosophical grounding. It stands in opposition to the Cartesian world view of psychological distress and the associated pathologising of problems with living. Rather, it is concerned with achieving a holistic understanding of the lived experience and this is done primarily by utilising the phenomenological method of revealing fresh perspectives of the client's experience.

As identified earlier, one of the key philosophical ideas underpinning existentialism is that concerning temporality; our experience of time and its centrality to the lived experience. Given the time-defined setting being explored in this research, this important concept is examined further in the following section ahead of an evaluation of ETLT.

2.2.3 An existential understanding of time

Since a key aspect of the current research is to investigate the existential approach within an explicitly time-defined setting, I considered it important to explore the literature in relation to time as a fundamental aspect of existence in more detail. How we are temporally engaged in the world and therefore how our possibilities and potentials are inevitably limited is a key tenet of existential thought, most notably as articulated by Heidegger (1962). His masterwork *Being and Time* offers surely the foremost proposition of how human existence is inextricably embedded within a temporal context. For this reason, in this section I focus predominantly on Heidegger's ideas although also explore the substantial but less referenced contribution from Minkowski ([1933] 1970).

While the scientific concept of time is that it is quantifiable, linear and entirely objective; temporality '*is the name of the way in which Time exists in human existence*' (Warnock, 1970: p.62). That is, temporality refers to how we engage with and experience time in our everyday living and how we are subjectively affected by it. Heidegger (1962: p.329) refers to the past, present and future tenses, or moments of time, as '*the phenomena of the future, the character of having been, and the Present'* which together constitute the '*ecstases of temporality'*. Just as our experience of time is temporary and transient, so is our existence; two inter-related givens from which we cannot escape. However, temporality is not to be understood as an entity in and of itself, for we (Dasein) *are* time, always and inescapably embedded in a temporal existence. He considers humans to be unique in having the ability to transcend the present and project towards the future where our possibilities, and the certainty of our death, reside.

Rather than a linear sequence of 'nows', there is a '*unity of the ecstases'* in which we experience essentially an amalgam of all three tenses where each is in relation to the other: '*the unity of a future which makes present in the process of having been; we designate it as 'temporality*' (ibid. p.326). He evokes here his former tutor Husserl's concept of a three-dimensional lived time in which a '*retentive*' (past) and '*protentive*' (future) influences how we experience the current. In other words, what we experience now inevitably involves our

past as well as projections of our future possibilities and can be best understood as a three-dimensional web. How we engage with these dimensions reveals how we relate to ourselves, as well as to others and the world.

Therefore when we recognise the value of time, when we acknowledge that we are finite, the more concerned and purposeful our living becomes: '*When Dasein concerns itself with time, then the less time it has to lose, the more 'precious' does that time become, and the handier the clock must be*' (ibid. p.418). The choice then is how to deal with this most fundamental and uniquely human concern. To confront it, indeed to embrace it can facilitate more purposeful living, mindful of its (my) transient nature. Alternatively I can work to deny or avoid this anxiety, something Heidegger calls '*evasive concealment',* to which we are all prone.

One such means of avoidance would be to take refuge and collude with those around us in the common predisposition to disregard or ignore that most uncomfortable truth – our approaching death. It is a strategy of avoidance, Heidegger (ibid. p.253) argues, that '*dominates everydayness so stubbornly that, in Being with one another, the 'neighbours' often still keep talking the 'dying person' into the belief that he will escape death and soon return to the tranquillized everydayness of the world of his concern*'. That is, when the possibility of the anxiety of facing death emerges for someone else, the collective tendency is for us to dispel the uncomfortable truth that the dying person is now confronting - for fear of the effect it will have on the rest of us.

Acknowledging this preciousness of time represents an awareness of the inherent limitation of one's possibilities and crucially, the certainty of one's death. When this awareness does emerge we experience ontological anxiety - the conduit for authentic living. This real engagement with our existence and potential requires a facing of the fact that we are at any time between birth and death, always becoming, and only ever complete when we cease to be. Heidegger calls this our '*Being-towards-death*' and it is perhaps the most fundamental concept of European existential literature, although also the key underpinning of Yalom's (1980) work in the United States.

Minkowski (1970), a French psychiatrist, also offered an important contribution which he developed from observing his schizophrenic patients. His ideas were significantly influenced by the philosopher Bergson ([1889] 1996) who had proposed that time, as well as space and the concept of causality, was best understood by first-person experiential accounts rather than any explanation offered by rationalism or natural science. As with Heidegger and Husserl, Minkowski believed that how we choose to relate to time reveals how we are in the world and so the extent to which our potential can be realized. He identified zones of time in which both the past and future could be understood as immediate, mediate and remote elements, and where the present is the zone of activity. Again these zones should not be considered in isolation since time is continuous and can be thought of as analogous to how we hear a melody. We are always engaged in a process of becoming and in the movement towards accomplishment.

Only in death can this accomplishment ever be considered to be complete and as such we make our way through life becoming but always with an associated sense of being unfulfilled or incomplete (Minkowski, 1970). Studying a patient with schizophrenic depression who portrayed an inability to engage with future-oriented thought and which resulted in him living in no more than a series of episodic moments, Minkowski pointed to the potency of our experience of time and how serious problems can arise. He posited that to be unable to fully engage and relate with the continual flow (or melody) of time could lead to severe psychological disturbance since such a person has become unable to live with the true nature of time and a necessary sense of becoming.

Taken together, it is I hope evident how lived time and our projecting towards the future and our possibilities and finitude are of eminent relevance to any therapy that is concerned with understanding a client's engagement with life. Perhaps it is equally evident how such concepts might be of particular worth in therapy that works explicitly within the constraints of time and the certainty of ending. Mindful of this, in the following section, I review the seminal contributions to time-limited therapy before specifically focusing upon ETLT.

2.3 Theoretical perspectives of time-limited therapies

There is a significant body of literature describing how the time-limited approach stands distinct from open-ended (e.g. Bor et al, 2004; De Shazer, 1985; Strasser and Strasser, 1997). While the terminology can differ (e.g. *brief*; *time-limited*; *short-term therapy*) the distinguishing characteristic is of a therapeutic contract that has an explicit and pre-defined contract duration, most typically of between around six and twelve sessions. Growing increasingly prevalent primarily due to practical and economic constraints, exponents posit that it should not automatically be considered an inferior substitute for longer-term work. Indeed some recent (quantitative) studies that have conducted follow-ups of between six and thirty months after brief counselling, client-participants reported beneficial outcomes concordant with objectives to have been maintained (Davis et al., 2008; Collins et al., 2012). Incidentally, in both studies, clients had received on average seven sessions. The argument regarding comparative efficacy to long-term, however, is not a particularly new one as O'Connell (2012) reminds us, Ferenczi and Rank declared back in 1925 that effective therapeutic work is not the preserve of long-term approaches.

Time-limited therapy has become a central strategy for addressing the increasing and already striking levels of self-reported work-related stress, depression and anxiety (Health and Safety Executive, 2010). Notably, more than a tool for symptom alleviation, there has also been a '*shift of the official focus towards considering the promotion of well-being, rather than a concentration on condition such as stress and depression*' (Collins et al, 2012: p.84) and this has included a recognition of the value of time-limited workplace counselling for such purposes.

Indeed most employee assistance programmes (EAPs) offered by companies to their staff typically follow brief models. Amongst the most common approaches adopted here is an emphasis on, or at least an integration of, solution-focused therapy (SFT) principles. SFT is underpinned by a social constructionist epistemology that acknowledges the context of the client's narrative (O'Connell, 2012). It encourages an egalitarian and collaborative working alliance with the focus being on what it is that can be changed. Developed originally by De

Shazer in the 1980s and with a usual duration of up to six sessions, the approach promotes principally a future-focused dialogue, aimed at harnessing the client's own abilities by utilizing generic '*skeleton key*' interventions (De Shazer, 1985). Although it is important to also make the point that all mainstream therapeutic approaches are represented in EAP settings; for one reflecting there being little evidence for differential effectiveness between orientations (McLeod, 2010). I would add a further reason for this being a pragmatic response by practitioners adapting their typically open-ended work to fit the brief frame imposed by agencies.

By describing the principles of working briefly, Bor et al (2004) offer a definitive and comprehensive account of the model and clearly differentiate it from open-ended approaches in a number of ways. First, they explain that the brief practitioner should actively challenge their client from the outset; something that they consider to be less likely when there is no explicit session limitation and so a less urgent pace can be indulged - and typically is. This echoes Koss and Butcher (1986) who suggested that one of the principle requirements of brief therapy was for the therapist to be active in the sessions and '*openly influential*'. Perhaps an obvious risk here is of being 'too active', with the client effectively being coerced into change or being persuaded to accept the practitioner's perspective as definitive. Both Koss and Butcher and Bor et al acknowledge this possibility but counter that while this is indeed something that the therapist should be mindful of, the emphasis is instead upon a collaborative endeavour to uncover solutions to problems. Throughout the process, and a fundamental intention of the work, is for the client's own resourcefulness and autonomy to be encouraged and nurtured (Bor et al, 2004). Nonetheless, certainly it would seem that any such potential for coercion, albeit benevolent and well-intentioned, should be recognised and monitored – perhaps a matter of course for the reflexive practitioner.

A further key distinction is that small changes should be considered to be both a realistic aspiration and, crucially, sufficient to instigate a larger and wider process of change which the client will continue them self once the therapy has ended. Instead of the assumption being that all issues are assiduously addressed in the therapy room, the main work goes on outside

of the room and beyond the contract (Bugental, 1995; Strasser & Strasser, 1997). The implied attribute of brief work then is that the client may more readily learn self-reliance and an increased sense of self-confidence in their own abilities (Woolfe et al, 2010).

In terms of approaches, Bor et al (2004: p.8) argue that a time-limited setting is relevant and adaptable to all mainstream theoretical orientations since the principle aim for the therapist will always be to ensure that a '*positive, strong, collaborative working alliance*' is developed as soon as possible. While this may be so and as discussed earlier, it is also important to stress that typically it is the therapies with an evidence-base (EBTs) that are predominantly represented, certainly the case in NHS service commissioning. Nonetheless, the key point from the authors is an important one - that the primary determinant of a beneficial experience is the development of a strong alliance irrespective of orientation.

Bor et al also suggest that a pragmatic and clearly defined objective for the work should be explicitly agreed at the beginning. They suggest that given the time constraint, the goal must be to focus on a unitary issue, or certainly few with minimal distractions or diversions. An agreed number of sessions in which to work towards achieving this defined objective should be equally unambiguous (they suggest between six and ten) and of course the approaching ending should be made explicit from the outset. Hoyt (1995) similarly suggested that time and the ending should always be present and open to discussion throughout the contract, arguing that the therapist must make a point of reflecting with the client how they are using the time they have together.

While unequivocally espousing the benefits of the time-limited approach, Hoyt (1995) nonetheless also argued that it cannot be considered universally suitable for all forms of problems with living. In particular, early life trauma or abuse typically takes time to be comprehensively addressed principally because the therapeutic relationship is one that can take significantly longer to develop. Beneficial changes tend to equally be at a slower pace and, crucially, require a period of consolidation while the client remains in therapy.

It has been my intention in this section to identify the salient distinguishing features of working in a time-limited setting and specifically show where it varies from longer-term working. I turn now to review ETLT, with a view to highlighting the key distinguishing factors as well as commonalities with the definitions so far explored and to further conceptualise the rationale for the current research.

2.3.1 Existential time-limited therapy

Literature defining and evaluating ETLT remains very limited with the Strasser and Strasser book (1997) enduring as the seminal reference, and as such I will spend the majority of this section exploring their ideas. This general sparseness in literature can perhaps be explained by a reluctance amongst existential therapists to be constrained by rigid timescales or objectives (Cooper, 2003) and a view that there can be no assumed '*quick fixes*' to the dilemmas and difficulties posed by life (Deurzen, 2002). From such a perspective, a time limitation for therapy addressing problems with living may feel somewhat arbitrary. However, Cooper (2003: p.129) argues that given the inexorable move towards time-limited therapy, it is an '*unavoidable*' reality that must be engaged with if we want the existential approach to be included in future service provisions.

From a similar pragmatic reasoning, Bugental (1995) offered some preliminary reflections on what ETLT would look like, a setting that he considered not ideal but nonetheless increasingly prevalent. He identified six distinct phases to the counselling including the assessment, establishing specific objectives and how to address ending. A notable teaching element is included in his framework in which he suggests we effectively coach the client on how to continue the process of exploration beyond the therapy sessions.

While Bugental approached time-limited therapy from a pragmatic appraisal of service provision, it is with Strasser and Strasser (1997) that a more positive stance is adopted, emphasising the unique opportunity and potential afforded by a time-limited framework. This includes first and foremost engaging with the existential givens of temporality and finitude, something which the setting uniquely provides. Indeed they differentiate the time-limited approach from longer-term existential therapy by proposing that temporality can be used as

leverage in the work: '*the one important distinguishing feature of time-limited therapy is the limitation of time itself. So although the goal is to achieve the same kind of awareness as outlined in an open-ended approach, the aspect of time becomes a tool in itself*' (ibid, p.13). It is a tool in that once there is an acknowledgement of time as being fundamental to the process (by making explicit that there is a definitive end date), a '*pressure*' is created for both the client and therapist to become mindful of the limitations that they face and the objectives that they aspire to meet.

They argue that this will fortify the commitment to the process and facilitate a more urgent and vital atmosphere that is conducive to change. The potency of the work is here since *'…the simple fact of knowing that there is an ending tends to evoke stronger emotions… so for instance emotions such as fear, anger, sadness and the recollection of previous losses and rejections help clients to identify their value and coping strategies'* (ibid, p.15). Unfortunately, with the engaging case studies that the authors include as examples of ETLT in practice, none seem to readily convey an intentional and explicit working with temporality or the anxiety of ending, despite this being what the authors themselves identify as the 'USP' of ETLT.

Nonetheless, this concept is crucially important to understanding the leverage available in time-limited settings generally; that if we are to benefit from a sense of urgency to the sessions, this can be best achieved by making explicit to the client the diminishing time available. The emerging anxiety can be utilised as a force for change since there will be an elevated focus upon outcome and achieving objectives. Incidentally, this evokes Mann's (1973) time-limited model which while largely grounded in psychodynamic principles also firmly positions working with temporality as fundamental to the process. Indeed he argues that by exploring any anxiety against the finiteness of the therapy, ontological anxiety associated with aloneness and isolation can be revealed.

However, and significantly in relation to this point of the potential in ending, Strasser and Strasser suggest that subsequent to two post-therapy follow-up sessions, another module of twelve sessions can be negotiated. This possibility, they suggest, should be highlighted to the client at the beginning of the initial contract. Bugental (1995) suggested similar by proposing

that towards the ending, a new series of sessions could be arranged. While I entirely agree that a rigid time-limited contract is not suitable for all presenting and emerging issues, this does seem to somewhat weaken the assertion to be explicitly working with the limitation of time and the certainty of ending. The key point being that if the client, and indeed therapist, are aware there can be a further module (albeit subject to review), the tendency might be to expand issue exploration rather than '*assiduously*' address them. In other words, the anxiety and associated drive to avoid the ending will prevail.

In fact the Strassers' acknowledge this as a possibility but consider the potential benefits of a modular approach outweigh such a risk '*by demonstrating flexibility rather than conforming rigidly'* to a single module (ibid: p.49). They cite further possible benefits including: clients not feeling rejected should they need further support and also the therapist retaining credibility in modifying their initial assessment of number of sessions required. Nonetheless, a central distinguishing feature of this model, that of time and utilising the anxiety of ending as a means for a more vital engagement in the therapeutic process seems to be rather diluted. This modular approach is perhaps better described by their own term for an essential element of *all* ET – that it should be '*time-aware'* (ibid: p. 4) or as Budman and Gurman's (1988) description, '*time-sensitive'*.

The Strasser model also includes an 'existential wheel' in which Yalom's (1980) four ultimate concerns - freedom, existential isolation, sense of meaninglessness and death – together with the four dimensions of existence described earlier (Binswanger, 1946; Deurzen, 1997) are featured. This is designed to provide a blueprint for practitioners to reference and assist understanding the client's predicament. While the wheel does offer a framework from which to work from, it does not seem readily evident how this is unique to a *time-limited* existential approach – or indeed that it should be. That is, it does not seem to be much more than a diagrammatic representation of already established existential frameworks.

As with open-ended ET, clients values are explored within the context of a life lived inevitably within the paradox of possibilities, limitations and choice; '*to distinguish them from the limitations that they impose on themselves*' (Strasser & Strasser, 1997: p.13). The pivotal

difference in method lies in the higher frequency of challenging and clarifying than in open-ended therapy which, they argue, '*catapults the client into self-disclosure and working more assiduously on issues*' (Strasser & Strasser, 1997: p.14). Again the argument being that a pace and sense of urgency is generated, concurring with key non-existential brief models (e.g. Bor et al., 2004). Significantly, however, and in distinct contrast to other brief frameworks, there should be no setting of specific targets or goals since all issues are '*inextricably linked*' (ibid, p. 15) reflecting the existential understanding of the lived experience.

Meanwhile, Langdridge (2006) argues that in fact time-limited existential practice is not necessarily incompatible with solution focused therapy (De Shazer, 1985; O'Connell, 2012) primarily because there can be a '*tighter*' focus and a greater emphasis on solutions. He posits that while existential therapy can typically be assumed to be focused upon the present, while informed by the past and future possibilities, a contract that is time-limited means that a greater focus upon the future is desirable, indeed *'may well be...appropriate'* (ibid, p.365). To achieve this, Langdridge suggests striking a balance between relevant (and essential) attention to the past and present concerns by description of one's predicament, while remaining mindful of the lack of time and forever focused towards reaching goals and actualising potential. This again evokes the sense of urgency and energy that are argued to be characteristic of time-limited approaches generally, while emphasising a particularly existential-oriented focus on the here and now in order to facilitate a more favourable engagement with future living.

Returning to the matter of presenting issues and the appropriateness of this setting to address them, the Substance Abuse Mental Health Services Administration in the United States (1999: Treatment Improvement Protocol (TIP) Series, No. 34.) recommended humanistic and existential time-limited approaches as being especially suitable to working with substance addictions. This is because of the emphasis on the early development of the therapeutic relationship; the engendering of self-awareness; resilience and resourcefulness; and so empowerment by encouraging a sense of choice and responsibility. Incidentally, the report also suggests that existential and humanistic time-limited approaches are compatible with twelve-step programs, since the emphasis is on *acceptance* of things that cannot be

changed and *courage* to make the changes that can be. However, given what we already know in terms of the phenomenological philosophical underpinnings of these orientations – specifically the rejection of the medical model - and since twelve-step programs as run by Alcoholics Anonymous, for example, consider addiction to be a *disease*, it would seem there may be some notable difficulties in any such collaboration.

To sum-up this important section in relation to the current research: collectively the authors offer a substantial theoretical contribution to our understanding of the value and relevance of working in a time-limited existential manner. They argue that by encouraging an engagement with the key existential concepts of responsibility, choice, temporality, the embracing of our limitations, possibilities and death within this particular context can facilitate a unique opportunity for a meaningful exploration of problems with living.

So far in this literature review, I have examined the socio-political context of CoP with particular attention upon the implications of the prevailing homogenisation of the profession - something which influential commentators deem to be no less than a major crisis for the discipline. I have also described how the philosophical underpinnings of the existential orientation are equally at the core of CoP. Bringing the focus towards the time-limited setting in which the current research is concerned, I have outlined the main models and theoretical arguments in support of this framework with specific attention upon ETLT, for which the literature is particularly limited.

I provide below an overview of key existential thought around sexuality and evaluate how this influences working with clients from sexual minorities. True to the spirit of the phenomenological method and reflective of the aforementioned BPS guidelines, I purposely chose not to assume issues with sexuality or HIV would be presenting factors for the participants (other than as criteria for accessing the service) and as such this section was added subsequent to the analysis of findings.

2.4 An existential understanding of sexuality

From an existential-phenomenological perspective, it is with the writings of Merleau-Ponty (1962) that human sexuality was first explored to any significant depth. It is essentially understood to be but one, albeit significant, way of being-in-the-world; an expression of *relatedness*. It is also influenced by the socio-cultural and political contexts of the day, and their associated discourse (Foucault, 1979). Sexuality '*'is always present like an atmosphere*' (Merleau-Ponty, 1962: p.168) and so, like existence itself, is not thought of as some-*thing* that can be readily identified or categorized. As outlined earlier in section *2.3.1*, Merleau-Ponty rejects the Cartesian duality of mind/body when describing the human lived experience and refers instead to *embodied consciousness.* That is, we both *have* and *are* a body; '*Our own body is in the world as the heart is in the organism*' (ibid, p.203); and it is through our body, including in expressing our sexuality, that we convey and realize our existence (Horne, 2009). Spinelli (1996, 2013), a current principal existential commentator on sexuality, prefers the term '*being sexual*' by way of emphasising how it is an aspect of existence rather than focusing upon the sexual encounter or behaviour.

Existentialism considers a biological definition to be wholly reductive and restrictive; arguing that while the goal of reproduction can of course be a reason or initiator of human sexual behaviour, it is far from being the only one. Nonetheless it is this view that has dominated contemporary thinking and, therefore, laws and attitudes since the 19th Century. As such, in terms of sexual desires and behaviours, this explanation has underpinned ideas of what is deemed to be 'normal', 'natural' and so acceptable (Spinelli, 2013). It is also from this same time that the term '*homosexuality*' emerged and when same-sex acts were proclaimed to represent '*a different sort of being whose identity and consciousness could be contrasted – pejoratively, to be sure – with heterosexual identity and consciousness*' (ibid, p.304).

Important here is the view that sexuality is considered a determinant of identity. Spinelli argues that these categorisations have set people apart based upon their sexual predilections, and in doing so, have imposed a fundamental sense of '*otherness*' on those who do not identify as part of the majority. By using such labels to describe identity, a benchmark for

establishing what is normal, natural or acceptable is arbitrarily set based upon the prevailing attitudes and values – with very substantial ramifications for individuals identifying as not-heterosexual. However, Plummer (1981: p.74) made the important related point that '*with all these categorisations comes the paradox: they control, restrict and inhibit whilst simultaneously providing comfort, security and assurances*'. Practitioners should, therefore, be mindful of this and not assume sexual-identity labels to be problematic for clients since they can also provide great value and succour for people whose experience has been that they do not otherwise belong (Spinelli, 2013).

I outline below some key perspectives around how ET practice engages with clients presenting with concerns related to being sexual.

2.4.1 Working with sexual minority issues

While the BPS acknowledges the significance of the American Psychiatric Association removing homosexuality from their list of mental disorders in 1973, it also recognises the continuing higher rates of mental health problems, including anxiety, depression, substance misuse, eating disorders, self-harm and suicide; and asserts that these '*problems are related to negative attitudes in society, and sometimes from prejudice and discrimination in health care and social services*' (Professional Practice Board, 2012).

Of course, as practitioners, we must not assume that gay men coming to therapy because of issues associated with sexuality, it is entirely feasible their presenting issues are unrelated (Davies & Neal, 1996; Richards & Barker, 2013). However, where issues around sexuality *are* the problem for the client, existential therapists will explore as they would any other – working on that which concerns them, as Deurzen-Smith, 1996: pp.177-8) describes: '*Existential therapists are fundamentally concerned with what matters to the client. He or she avoids making normative judgements, and renounces any ambition to, even implicitly, push the client in any particular direction*'. Similarly, and writing as an ET practitioner who regularly worked with gay men affected by HIV, Horne (2009: p.64) argued that '*it is crucial for me to attempt to understand and appreciate the various stances which each client adopts towards*

themselves and the world. This presents me with a challenge, as I have to abandon any notion that I know what is best for my clients'.

This assumption-less and agenda-free stance that characterises ET would clearly appear to be at odds with how gay affirmative therapies are often understood, an approach which in the UK the *Pink Therapy* series by Davies & Neal (1996, 2000) remains the seminal guide to practice. In what Langdridge (2007b) describes as the 'strong' version, it is recommended that the gay affirmative practitioner utilises their professional authority to promote gay identities and practices and encourage the client to adopt and integrate a similar attitude. Certainly, it is difficult to see how adopting such a stance would not compromise the assumption-less and agenda-free stance of ET. Indeed, any notion of the therapist using their 'professional authority' in the dyad is entirely antithetical to the collaborative and co-created therapy relationship that is at the core of ET and CoP practice.

However, Harrison (2000) has highlighted how the associated literature is inconsistent and this is reflected in there being significantly less controversial aspects that can be considered to be largely transtheoretical. For example, Milton (1998) replicated a study commissioned by the American Psychological Association (Garnets et al., 1991) which sought to capture counselling psychologists' views on good, and bad, practice for practitioners working with LGB clients. Some of the key recommendations that emerged from this were: that practitioners should openly convey - and have – an accepting attitude to sexual diversity; they should acknowledge the adverse impact of persecution and prejudice and be knowledgeable of the particular issues faced by this client group; and they should be cautious about applying heterosexual frames of reference. Such recommendations are readily compatible with the accepting, respectful and non-judgmental attitude that is characteristic of both ET and CoP practice.

In the following section I bring together the key conclusions and implications from each area covered in this chapter by way of reiterating the rationale for the current research.

2.5 Rationale of the current research

As shown in the preceding review of the existing literature, there is a substantial and ever-growing body of research substantiating the value of CoP generally (including each of the three main traditions that constitute it) as a means of addressing problems with living and promoting wellbeing. However, the 'evidence-base' remains predominantly heavily weighted in favour of empirically supported therapies, and it is from this that policymakers base their decisions upon the inclusion of particular modalities. This in large part explains the current overwhelming dominance of CBT in the NHS, for instance. As discussed, key commentators have pointed to such an ever-increasing homogenisation within CoP reflecting a departure from the core characteristics of the profession; namely pluralism and the fundamental acknowledgement of the individual's subjective lived experience.

It is within this context that existential-phenomenological therapy, while sharing key philosophical underpinnings with CoP, has been largely excluded from mainstream provision. This is primarily on account of it having a very limited research base from which its inclusion could be justified. Moreover, while the time-limited version of existential therapy has been defined, with the exception of anecdotal case studies, there remains a dearth of research showing how it is actually experienced and what it offers. Since much of the publicly-funded and third sector services provide therapies that are brief or time-limited (often on account of austere resource constraints), it seems timely for ET in this particular format to be researched.

In seeking to understand and 'prove' the viability of particular therapy services, one common method of measurement is utilising 'before and after' standardised questionnaires such as CORE-OM, as is used at HCS. While such measures are surely informative, what we cannot ascertain from them is what was actually experienced by clients during the therapy contract and how, if at all, it actually helped as intended and needed. Further, and as shown in the preceding review, there is a now a substantial body of research identifying the therapeutic relationship as being the foremost determinant of a successful outcome for clients across orientations within CoP. However, while this has been largely accepted, what remains less clear from the existing literature is *how* the relationship makes a difference.

To summarise the above points:

- The pluralism that characterises counselling psychology is being threatened by the demand for 'evidence' and uniform treatment protocols
- Continuing lack of a knowledge-base of existential therapy in practice
- Relational factors widely acknowledged as pivotal to positive outcome but *how* these factors contribute is less clear
- Prevalence of time-limited therapy across major providers but no existing knowledge-base of existential time-limited therapy in practice and specifically how it is experienced by service users

It is from these limitations and challenges for the profession that the rationale for conducting the current study developed. The research question to be specifically addressed is as follows: *how is existential time-limited therapy experienced by this particular group of service users at an HIV counselling agency, and can it be considered to be an effective option for addressing their needs and objectives?*

2.5.1 Research aims and focus

Based upon the above outlined rationale and research question, I identified five specific areas that I invited the participants to reflect upon:

1. *Presenting issues and objectives - what were the participants' hopes and expectations as they began the existential time-limited therapy at HCS?*

2. *The therapeutic process – what, if anything, actually emerged for the participants during the therapy contract*?

3. *Outcome - what, if anything, did the participants take from the therapy and how have they been affected by it?*

4. *How did the participants' experience the therapeutic relationship in this setting?*

5. *The time-limited frame - did this influence the work for the participants in any way and if so, how?*

2.6 Reflexive process

This research topic is something I have previously written about by presenting a case study of my own (Lamont, 2012), and so there is no question I held a fairly established view as I began this process. Further, as previously alluded to, I am a practicing existential psychotherapist and trainee existential counselling psychologist who is acutely aware of the current drive and appetite for evidence-based practice in our profession. For one, I experience it first-hand when applying for jobs. There is undoubtedly a pressure on essentially non-CBT approaches that have no such wealth of evidence to prove their viability.

To ensure the integrity of the research it was essential for me to both acknowledge and remain vigilant to this position when collecting the data and perhaps especially so when subsequently analysing and constructing conclusions. However, as Finlay (2008b) reminds us, reflexivity is about more than me simply acknowledging this and assuring the reader of my self-awareness and vantage point. It is about understanding how this position could affect the research - addressing how my lived experience and worldview can affect how I engage with the research and ultimately influence my interpretations. This demands a continuous and dynamic process of monitoring when, what and why I do what I do throughout the research lifecycle (Etherington, 2004).

While an inherent aspect of the existential-phenomenological position is to bracket one's assumptions and biases as much as possible, that I am subjective as a researcher is assumed from a CoP perspective (Kasket, 2012). Parker in Banister et al (1994: p.13) argues that providing one is clear and grounded in one's position '*subjectivity is a resource, not a problem…When researchers whether quantitative or qualitative, believe that they are being most objective by keeping a distance between themselves and their objects of study, they are actually...producing a subjective account, for a position of distance is still a position and it is all the more powerful if it refuses to acknowledge itself to be such*'. By acknowledging this inherent subjectivity I accept that my vantage point is but one view. By definition, someone else embarking on the same research may well present quite different valid conclusions.

What matters most is that I am accountable, transparent and continually reflexive in my engagement. The goal must therefore be for me to instil rigor as much as possible (Kasket, 2012) while for the reader to acknowledge that no matter how rigorously research is conducted, biases will emerge and this requires of them to approach the research with a critical eye, '*paying attention to the background and context of whoever conducted the research and what their agendas might be'* (Cooper, 2008: p.4). Returning to Parker in Banister et al (1994: p.13), he refers to our '*moral responsibility'* as researchers to recognise and '*to allow readers of the report to offer different interpretations...this...opens the research to a reflexive survey of the assumptions that have guided it'*.

Specifically in terms of the current research, the fundamental aim was to capture experiential accounts from participants and this meant being open to wherever they wanted to go with their reflections. Nonetheless, undoubtedly a risk and question was how my stance - as an existential researcher-practitioner - might affect my ability to accurately reflect what my participants are reporting. This has incidentally been described as '*researcher allegiance'* effects (Luborsky et al, 1999), referring to how researchers have demonstrated a tendency to produce results that compliment their own theoretical orientations. Cooper (2008: p.47), in his comprehensive review of process research, cited this as '*one instance of the more general phenomenon of 'experimenter-expectancy' effects'* referring to Christensen's (1997) research that had shown how such expectations affected test outcome.

In practical terms, one important monitoring tool for me was maintaining a diary during the project in which I captured my responses and reactions to the participants' material as it emerged. I will discuss further my reflexive process as I proceed through this report including in the pivotal Findings chapter. In the following chapter, where I discuss the research methodology, I will also expand upon the ethical implications of the researcher-practitioner duality alluded to here and how I attended to them.

3. Research Method

Pivotal to any research project is of course understanding the method that underpins it. Having outlined in the previous section the rationale for my project by reviewing the associated existing literature, in this chapter I explain my epistemological vantage point and in particular show how this determined and guided the research method adopted.

This research is positioned within the principles of hermeneutic phenomenology, a stance most notably espoused by Heidegger ([1927] 1962), Gadamer ([1975] 1996) and later van Manen (1990). At its core, hermeneutic phenomenology embraces the notion of us being always and inevitably subjectively engaged in an interpretive meaning-making process when contemplating the lived experience of ourselves and of others. Forrester (2010: p.17) identified some fundamental questions underlying the uncovering of knowledge, beliefs and 'truth': '*How do we recognise knowledge when we see it? How can we determine what a fact is? What is truth and how do we know when we've got it?*' My existential training and experience as a practitioner have informed me that by encouraging our clients or participants to describe their feelings, values and emotional responses to the world in which they are engaged, we can explore and reveal their unique worldview – *their* truth - within the confines and safety of a collaborative therapeutic alliance. This enables current assumptions to be challenged and alternative ways of being contemplated ever mindful of the contextual realms and relational matrix in which we all exist.

In this chapter, I explain my reasoning for selecting Interpretative Phenomenological Analysis (IPA), developed by Smith in 1996, as my research method and include an account of the alternative methods considered during the design phase of the research. I go on to provide a detailed description of the preparation and implementation of the data collection process and of the subsequent analysis. The chapter concludes with an exploration of my reflexive

process across these pivotal stages of the research. However, by way of understanding and positioning the epistemology, I turn first to an overview of what is meant by phenomenology.

3.1 Phenomenological method

Phenomenology as a research methodology emerged in the 1970s, led by Amadeo Giorgi and the Duquesne Circle (Wertz, 2005). Their explicit aim was to create a method, modelled upon traditional scientific principles (including criteria such as replicability), while at the same time acknowledging that knowledge cannot be separated from how we understand the lived world. It is underpinned by Husserl's (1967) concept of *Lebenswelt*, or *Lifeworld*, which constitutes the focus for phenomenological investigation and comprises the cultural, temporal, social and embodied contexts in which we all exist. This perceiving occurs before we can be aware of it and so is concerned with how we pre-reflectively experience the objects around us as well as our own physical self. As Finlay (2008a: p.1) argues, the central idea of Lifeworld '*is that we exist in a day-to-day world that is filled with complex meanings which form the backdrop of our everyday actions and interactions*'. Utilising Husserl's eidetic reduction method (as described earlier in section *2.3.1*), the goal of transcendental phenomenological research is to examine by way of bracketing one's presuppositions of the fundamental structures of a phenomenon as it presents itself (Giorgi, 1985; Giorgi and Giorgi, 2003). In other words, the intention is to bring to awareness and identify the actual characteristics of what is being examined by how they are revealed to us.

Fundamental to this is acknowledging and, crucially, doubting our predisposition to view the world experientially, through a lens of bias and assumption. For Husserl, this was our *natural attitude* and as Langdridge (2007a: p. 17) explained, it is our '*most basic way of experiencing the world, with all our taken-for-granted assumptions in operation'*. Therefore our lived experience determines that which can *subsequently* be described and understood: 'living precedes *knowing*...we have experiential relationships with the world before we objectify our experience...Consciousness is always of the world' (Deurzen & Kenward, 2005: p.96; emphasis in the original). The goal is to expose the hidden essential features of the lived experience. An intrinsic part of this is the process of *imaginative variation* which involves introducing

alternative components or different perspectives in order to strip away and arrive at the true meaning of the phenomenon, unhindered by the natural attitude (Langdridge, 2007).

The transcendental phenomenological approach therefore represents a fundamentally relational and subjective understanding of human existence and as such philosophically underpins the existential-phenomenological heritage of counselling psychology and qualitative research. However, the intended scientific rigour has been questioned by phenomenological psychologists, including advocates of the method, arguing that it is ultimately an impossible endeavour (e.g. Dahlberg, Drew and Nystrom, 2001). Specifically, they query the viability of comprehensively bracketing one's worldview, claiming that at best this can only ever be partially achieved and therefore any subsequent findings or conclusions derived from this method must be regarded with a degree of caution. It is from this core criticism and marking a distinct departure from the Husserlian descriptive approach that more interpretive approaches emerged, the defining characteristics of which I describe in the following sections.

3.2 Hermeneutic phenomenology

Heidegger (1962) led this move from descriptive to interpretive phenomenology, typically referred to as the '*hermeneutic turn*' by arguing that accessing a lived experience can only be done through interpretation since we cannot ever discard our pre-acquired knowledge. As explored within the Literature Review (2.3.1), at the core of this position is the view that since our embodied being exists contextually – temporally, historically, socio-politically and spatially– it can only ever be understood within this milieu and never separate from it. For Heidegger, we are in the world *and* the world is in us. In other words, we are inseparable from the world into which we are thrown and how we are within that cannot be understood by somehow stripping away or disentangling us from this relationship. Merleau-Ponty (1962: p.xi) was also a foremost proponent of this idea of our being inextricably embodied in the world and argued that acknowledging this is essential to adequately comprehending a lived experience: '*There is no inner man [sic], man is in the world, and only in the world does he know himself*'. Therefore, from an existential-phenomenological perspective, reaching

understanding or deriving meaning cannot be achieved by engaging in an intra-psychic exploration.

Our embodied consciousness both connects us to the contextual world and determines how we perceive it. As such, any 'truth' can only ever be subjective and situation-specific and so may well be different in another circumstance. Finlay (2008b: p.107) urges caution in the claims we make from phenomenological research since neither researchers nor participants '*have privileged access to the 'reality' of our lived experience. When we narrate our experience we offer one version - an interpretation - which seems to work for that moment*'. Therefore, we must remember that all findings and reflections are tentative and subject to change and so all description is uncertain; this is the very basis of hermeneutic phenomenology.

Gadamer ([1975] 1996), another hugely influential figure, emphasised the central importance of dialogue and as such his ideas are of particular relevance to explaining the epistemology of the current research. Mentored by Heidegger, he argued that understanding is reached through language and conversation since the world is revealed to us through a combination of our own interpretation and the sharing and exchange of ideas with others *in dialogue*. By questioning, and crucially, being open to whatever answer is received, we can '*provoke*' our pre-acquired knowledge and fore-understanding. This is pivotal to the hermeneutic phenomenological stance - the view that we approach analysing a text with a subjective and historically-shaped interpreted knowledge. By recognising and acknowledging this we can facilitate the new information conveying whatever it intends to: *'(T)he important thing is to be aware of one's own biases and assumptions – our natural attitude - so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings*' (Gadamer, 1996: p.269). Bringing into awareness our natural attitude is a crucial aspect of research and practice and is achieved by an ongoing engagement with one's reflexive position (Finlay and Gough, 2008).

The hermeneutic turn described above constitutes a fundamental philosophical and epistemological shift from the Husserlian 'purist' phenomenology; whilst nonetheless

remaining undoubtedly grounded and informed by it. I turn now to summarizing the epistemology of the current research based upon the arguments outlined so far in this chapter.

3.2.1 Epistemology of the current research

The research topic itself effectively determines the research method, a point emphasised by Willig (2008 p.13): '*what matters is that we identify, clearly and correctly, what type of knowledge we aim to produce and that we select a research methodology that is designed to generate that type of knowledge'*. What matters in other words is that we are clear about what we want to explore and the research method that is best placed to achieve that.

Specifically, this research is about understanding the unique lived experiences of a small group of people in a particular setting. As part of this I recognise that my equally unique lived experience of conducting this investigation will contribute to the shape of my findings. Therefore, this project adopts a critical realist position (Willig, 2008) which accepts a person's reality as *their* truth and so starts from the 'purist' realist position in line with phenomenological philosophy, but also accepts that knowledge is not formulated in isolation. Participants' experiential accounts are by definition subjective and interpreted, informed by their worldview and the contexts in which they exist and so embraces the hermeneutic phenomenological stance. My epistemological position therefore acknowledges this subjectivity inherent in the process of understanding and attributing meaning.

In line with this epistemological position, I decided that IPA was most appropriate as the method of qualitative analysis. In the following sections I will elaborate on the characteristics of IPA, consider the key criticisms of it and explain how I considered alternative methods before finalising this decision.

3.3 Interpretative Phenomenological Analysis

Based upon the epistemological position outlined above, I identified IPA as the most appropriate tool for analysis of the interview data. The method contends that to understand

the lived experience requires investigating *how* it is experienced and what meaning is attributed to it by the individual. A variant of thematic analysis, IPA involves the repeated and systematic re-reading of the text from the interview transcripts. By following this iterative exercise and working through the interview transcript, the major themes (as interpreted by the analyst) emerge. This is first conducted for each participant in order to describe and interpret the reported experience of the individual before conducting a cross case analysis of the group of participants to search for commonalities in their reported experiences (Smith et al, 1995; Smith and Osborn, 2003, Smith et al 2009).

Engaging with this evokes a principle tenet of hermeneutic theory and which underpins IPA - the *hermeneutic circle* (Gadamer, 1996; Smith et al., 2009). This refers to the interrelationship between the whole and its' component parts: to understand the former we must look to the latter, and vice versa. Therefore In terms of analysing a text, a single word could be considered a component, while the sentence in which that single word resides would be the whole. Following the same principle, an extract would be considered in relationship to the complete text. As the researcher, I am therefore engaged in a process of continually and repetitively focusing in on the detail and stepping back to view it within its' wider context, and vice versa; all the while acknowledging the fore-understanding or constructions that I bring to the endeavour. Analogous to a dance; between the interpreted and the interpreter, the implicit and the explicit, and between the component and the whole; our understanding of the phenomena under investigation deepens as we move back and forth between the two.

IPA is an idiographic and inductive form of analysis designed with the resolute intention to focus upon a specific experience. The aim is to develop a detailed formulation from a small group of people sharing and reflecting on a common experience. Crucially, this is done while at the same time acknowledging and understanding the uniqueness of each individual within the group (Harre, 1979; Langdridge, 2007a; Willig, 2008). The method is therefore interested in examining '*a particular experiential phenomena...understood from the perspective of particular people, in a particular context*' (Smith et. al, 2009: p.29). This represents a fundamental difference from quantitative (or nomothetic) research which, as has been shown

in Chapter 2, is principally characterised by the objectivist and deductive approach of stripping away or isolating variants for the purpose of revealing a scientific law or theory that can be attributed to a wider population.

Nonetheless, Harre (1979) also makes the crucial point that conducting qualitative research does not automatically imply a rejection of the value and importance of nomothetic literature in favour of only idiographic. However, by first understanding human behaviour through an inductive engagement with specifics, we can gradually and systematically build-up the knowledge towards reaching an informed position in which to suggest potential generalities. Thus the argument is not against generalizing per se, but that the very complexity of human psychology, something which Willig (2008: p.183) described as '*the messy and chaotic aspects of human life'*, is best acknowledged and understood by beginning at the bottom. IPA facilitates such a process of starting with the particular by identifying both the commonalities *between* participants as well as the *within* each participant's unique subjective account. IPA, as Shaw (2001: p.49) argued, is '*an ideal revealing analytic technique that provides an in-depth understanding of both the idiosyncratic and culturally constructed aspects of a person's Being-in-the-world'*. Herein resides the richness of the individual lived experience and which lies at the core of the aims for this research.

It is of course an essential aspect of research design that we conduct a comprehensive and pragmatic appraisal of the likely research method to facilitate reaching a sufficiently well-informed decision. This includes acknowledging and engaging with the criticisms and challenges posed in terms of its validity. As perhaps with all methods, IPA is not without detractors and, as already shown above, it certainly has been heavily criticised from the realms of transcendental phenomenology (e.g. Giorgi, 2010, 2011). In the following section, these principle criticisms are explored in more detail.

3.3.1 Challenges to IPA as a research method

Perhaps the strongest challenge to IPA as a phenomenological method comes from Giorgi (2010), the pioneer of transcendental phenomenological research methods and so proponent of a purist application of Husserl's phenomenological method. Giorgi's central charge is that

IPA bears no relation to the fundamental principles associated with philosophical phenomenology, which should be about describing the things as they are. To make this point, Giorgi cites MacLeod (1947: p.194) who argued how phenomenological enquiry is about '*the systematic attempt to observe and describe in all its essential characteristics the world of phenomena as it is presented to us*'. For Giorgi, IPA makes no attempt to do this and as such he questions why 'phenomenological' should even be in a part of its' name: '*the originators of IPA have given no indication as to how their method is related to the method of philosophical phenomenology. It would have been a lot clearer if [they] had termed the method Interpretive Experiential Analysis (IEA)*' (2010: p.6).

In particular, he points to a lack of rigorous *scientific* method in IPA which he considers to be an unacceptable weakness. Specifically, the absence of *replicability* is, he argues, a fundamental failing for any method that lays claim to being rooted in phenomenological research methodology: '*the ability to check the results of a study or to replicate it is a scientific criterion, and phenomenologically grounded science accepts that criterion…Thus to sponsor a 'non-prescriptive method' is an example of poor science*' (ibid, p.6). In other words if we cannot repeat findings, we cannot claim reliability and validity for our research; and if we cannot claim these then it is by definition poor science. However, Smith and Osborn (2008: p.67), argue that this lack of replicability is largely inevitable in an intentionally non-prescriptive method which they encourage to be '*adapted by researchers, who will have their own way of working*'.

Moreover, IPA does not lay claim to replicability, nor should it. As has been outlined and argued in Chapter 2, qualitative research rejects positivist traditional scientific principles. The very fact we cannot repeat since we cannot eradicate or segregate interpretation from description should be celebrated by phenomenologists whose entire philosophy is underpinned and informed by an embrace of subjectivity. Therefore while one would of course demand replicability as a reflection of rigour in an objectivist scientific study, a study of human engagement within a lived context cannot be about isolating variables or testing null hypotheses. Nor can we expect not to bring ourselves as researcher to the process in

terms of our pre-acquired conceptions and subjective stance, a point made by Smith and Osborn (2003: p.51) who argued it is inevitably a '*two stage interpretation process, or double hermeneutic…The participants are trying to make sense of their world; the research is trying to make sense of the participants trying to make sense of their world*'.

Accepting this argument was the principle determinant for me in considering IPA as the most appropriate method for the current research. That is, I acknowledge as inevitable the subjective and interpretive position of both the participant and the researcher; and IPA incorporates and facilitates this stance. My research is an idiographic study of the experiences of a small number of people using a counselling service. The core aim has been to capture key themes that emerged for these service users by way of their interpretations of their experience, and my subsequent interpretation of those interpretations. It would, in my view, be '*poor science*' were I to seek to generalise from this to a wider population, less still suggest another researcher with their equally unique worldview could replicate my particular findings.

I do, however, also think that there is considerable merit in the argument that to allow substantial freedom to adapt the IPA method introduces the potential for it becoming something else altogether. It does not seem clear, for instance, how much adaptation is acceptable and what would be gauged as being excessive. Indeed Smith (2010) commented himself that while IPA continues to grow in popularity, this does not necessarily correlate with high quality nor of the research conducted being necessarily congruent with IPA theoretical principles. Mindful of this, he outlined what, in his opinion, an IPA study should consist of:

1. It should have a clear focus
2. Contain strong data
3. Be rigorous throughout
4. There should be sufficient space for elaboration allocated to each theme
5. The analysis should be interpretative instead of mainly descriptive (as many seem to be)
6. The analysis should show differences as well as commonalities in the emergent themes
7. Be well written and engaging

Many of these guidelines could of course be considered applicable to all research. A further point made by the method's designers is that where there are any modifications made to the proposed template, they should be documented and the reasoning clearly explained.

A further important issue from an epistemological perspective is that IPA has been criticised for theoretical inconsistency, most notably with regards its alignment with social cognition (e.g. Langdridge, 2007a; Willig, 2008). Smith and Osborn (2003: p.52) declare that '*IPA shares with the cognitive psychology and social cognition approaches in social and clinical psychology (Fiske and Taylor, 1991) a concern with mental processes*'. However, as we have seen, a fundamental underpinning of phenomenology is its' view of the relational nature of consciousness. That is, how we subjectively engage with the world and others around us and so crucially it rejects the Cartesian intra-psychic understanding of consciousness and mind-body dualism - or '*ghost in the machine*' (Ryle, 1949, 1984).

Phenomenological psychologists are interested in the intentional relationship between consciousness and the world and so, as Langdridge (2007a: p. 13) states, are '*not concerned with understanding cognition, looking inside people to understand what is going on inside their heads*'. This, therefore, complicates any positioning of IPA as avowedly grounded in phenomenological philosophy. However, in practice - and providing the researcher's focus remains one of meaning-making and '*resisting the urge to speculate about cognitive processes*' – this theoretical nod towards cognitive social psychology makes little difference to the research process and subsequent findings.

In presenting and addressing some of the core criticisms of IPA above, it has been my intention to show how I have engaged in a detailed appraisal stage before ultimately concluding that IPA was an appropriate choice of method, taking into account both the research rationale and my epistemological stance. Before reaching this conclusion, however, the appraisal process also involved due consideration of a number of alternative methods, which I reflect upon below.

3.3.2 Consideration of alternative research methods

All research methods have limitations. Indeed, Rogers (in Kirschenbaum & Henderson, 1996: p.284-285) commented that '*phenomenological methods are not the best tool of research, but simply one tool appropriate to some kinds of situations*'. The most important aspect in terms of identifying the research method is maintaining focus on what is being researched and the knowledge that we are seeking to generate. Willig (2008: p.13) makes this point when arguing that '*what matters is that we identify, clearly and correctly, what type of knowledge we aim to produce and that we select a research methodology that is designed to generate that type of knowledge*'. As such, the purpose of this section in explaining my consideration of alternative qualitative methods, and why I rejected them in favour of IPA, is to evaluate them in relation to my epistemological vantage point. There is no intention or attempt to criticise or discredit any particular method per se but rather to simply assess their degree of appropriateness to what was being researched.

To this end, I describe below my consideration of four such methods, on account of them being either commonly considered as a viable alternative to IPA and/or sharing with IPA similar philosophical underpinnings. They are: Grounded Theory, Discourse Analysis, Template Analysis and Critical Narrative Analysis.

- **Grounded Theory (GT)**:

  Originally developed by Glaser & Strauss (1967), this has often been identified as the principle alternative to IPA (Smith et al., 2009). Mainly on account of its' longevity, it has evolved into a number of variations with the constructivist version (e.g. Charmaz, 2006) now being the most commonly used in psychology research. The core intention of all versions is the generation of a theory based upon what is being investigated; as Glaser and Strauss (1967: p.35) explained: '*both the process of category identification and integration (as method) and its product (as theory)…provides us with an explanatory framework with which to understand the phenomenon under investigation*'.

Therefore GT works from the premise that there is something to be discovered which will emerge from the exploratory process – that 'something' is simply waiting for someone to reveal it. Willig (2008: p.44) uses the analogy of a mid-wife delivering a fully-formed baby to help articulate the positivist epistemological underpinning which influences GT. Such an influence, she argues '*reflects the belief that phenomena create their own representations that are directly perceived by observers*'. This runs counter to my epistemological stance and research aim of investigating with a small number of participants, their subjective, interpreted accounts of a shared experience from which to uncover commonalities and differences.

My research being an idiographic study involving a small participant sample by definition means that one cannot purport to be uncovering social processes and so generating a theory attributable to a wider populous. As stated, I have no intention to do so but because GT studies do, they typically involve a much larger number of participants than is usual with IPA. This said, while IPA is concerned with '*the micro analysis of individual experience, with the texture and nuance arising from the detailed exploration and presentation of actual slices of human life*' (Smith et al., 2009: p.202) and so is not about making the sort of macro level claims that GT does; it is certainly feasible that the findings from an IPA study could form the foundations for subsequent GT research.

- **Template Analysis (TA)**:

  Developed by King (1998), less well-known than IPA but nonetheless involves a very similar analytical process in that both methods employ semi-structured interviewing and produce a *thematic analysis* of the experience under investigation. However it is also very different in that unlike IPA where themes transpire from the data, TA uses 'preselected codes' established from previous research as a template for analysing the new data. As Langdridge (2007: p.125) explains, while IPA '*is always inductive and grounded in the data with themes emerging from the text*', with TA '*a template of themes is constructed before reading the transcript and (is) then used to examine the*

data for meaning'. TA can also employ questionnaires in order to determine the themes that will subsequently be discussed in the interviews and as such can require significantly more participants than IPA does (Hefferon and Gil-Rodriguez, 2011).

One advantage of utilising templates devised from *a priori* knowledge can be that we approach the data mindful of and assiduously attending to what has already been identified as theoretically important. At the same time, TA also allows for the meaning that the participant attributes to the phenomenon to emerge. Nonetheless, this is a much more researcher-centric approach. I wanted first and foremost to hear and reflect upon the participants' experiential accounts free of predefined theory, allowing for the unpredictability and element of surprise that IPA offers. That is, while embracing the double hermeneutic concept and so acknowledging that this is a co-created piece of research, my intention was to facilitate a participant-led form of phenomenological enquiry as much as possible.

- **Discourse Analysis (DA):**

  There are several variations of DA but the two principal versions are generally agreed to be Discursive Psychology (DP) and Foucauldian Discourse Analysis (FDA). DA is philosophically broadly underpinned by social constructionism and as Wiggins and Riley (2010: p.138) explain: '*the main aim is to understand how talk and text construct particular versions of reality*'. A potential advantage is that it does not prescribe or define a specific procedure to follow, so affording a substantial degree of flexibility and adaptability to many research questions. Wiggins and Riley identify the common principles of DA as being:

  - discourse constructs and defines our social world, as such is worthy of being investigated
  - through analysing the language used, the consequences of creating a reality based upon particular social constructs can be contemplated
  - we can then think about how our way of being is defined and/or constrained by discourse

While DP and FDP share these aspects, they also each have distinct emphases. For DP, the focus is predominantly upon *how* people use language (spoken or written) for the goal of interaction; so the functionality of the discourse in a given context is the main point of interest (Potter and Wetherell, 1987). While for FDA, the primary focus is power and how discourse functions to shape and constrain our way of comprehending something (Parker, 1992).

Considering my research setting and the particular group represented, I believe a DA investigation into how social processes and discourse influence and affect their lived experience could be especially informative and would be of much interest to me personally. However, in terms of my research focus, while I acknowledge the fundamental importance of discourse and the socio-cultural and historical contexts within which my participants, and I, exist; I want to understand and give voice to the personal sense and meaning they made about a particular experience. That is, to make explicit through language their holistic experience of being in the world in this specific circumstance. As such, my focus is hermeneutic, idiographic and contextual: it is an interpretation of the meaning derived by particular persons in a particular context – this is not the intention of a DA investigation. IPA, however, does facilitate such an engagement.

- **Critical Narrative Analysis (CNA):**

  CNA is a form of narrative analysis proposed by Langdridge (2007). It is heavily influenced by the theoretical framework of Ricoeur (1970) which was rooted in phenomenological philosophy (including hermeneutics). Most notably perhaps, Ricoeur was influenced by the work of Gadamer ([1975] 1996) and the latter's emphasis on understanding through language and reading text. Langdridge (2007: p.43) makes this point by arguing that Ricoeur '*recognizes the embodied being-in-the-world of human beings that is beyond and pre-exists language, and an interpretative understanding of human nature through language*'.

Ricouer developed his work with a focus upon phenomenological time (1984, 1985, 1988) in which he argued that our personal narratives situate our experience temporally. Given the focus of my research is on the experience of existential time-limited therapy, this method particularly captured my attention in the initial stages of design. I will therefore briefly outline the key features of CNA before explaining why it was not the most suitable for my research aims.

The central focus is around uncovering the participant's life story and so essentially aims to build a biographical account. McAdams (1993) described how a narrative analysis researcher will ask about eight key events in the research interview including: earliest childhood memory, optimum experience, worst experience, life turning points, future plans. There then follows six stages of analysis (including identifying narratives; their tone and rhetorical function; thematic priorities and relationship, and destabilizing the narrative and synthesis). The Langdridge variation of this is an additional – *critical* – step in which the text is interrogated using '*a hermeneutic of suspicion*'; a key further stage intended to reveal the implicit meaning within a text.

CNA typically works best with a single case study since the aim is less about looking for commonalities and more about the detailed analysis of a presented life story. Although Langdridge states that it is possible to conduct CNA with a small number of participants, he warns that it is a very labour-intensive and complex process. Most importantly, however, while understanding the life narratives and indeed the context within which the participants existed was of considerable interest, it was not the aim of my research. As surely revealing and informative as that might be, again my focus was instead upon the experience of a particular life event by a small group of participants for the purpose of describing, interpreting and identifying commonalities and existential themes. It is for this reason, therefore, that I ultimately concluded that IPA was the method most aligned to my epistemological stance and research rationale.

Having discussed the decision process involved in identifying IPA as the research method for this project, I turn now to another seminal aspect of the research; the consideration of ethical questions and issues.

3.4 The ethical imperatives of research

The purpose of this research was to record, analyse and report the experiential accounts of a small number of recent users of a counselling service. A key part of this process has involved attending to the associated ethical dilemmas and questions that emerged in order to safeguard the wellbeing of the participants. Before addressing the applied aspect of the ethical standards and protocols, I discuss below what we actually mean by ethics in counselling psychology research.

3.4.1 Research ethics in context

As discussed in Chapter 2, the ascendancy of Cartesian objectivism (and the associated rise of scientific research universities) meant that studying the subjective, socio-historical and culturally-influenced experience was largely displaced by deductive observations of human behaviour (Bellah et al., 1985). However, within this climate of investigating phenomena in '*value neutral environments*' (Brinkmann and Kvale, 2008: p.264), a renewed interest in qualitative research has emerged in the past decade. It is within this context that counselling psychology's commitment to subjectivity and the relational milieu of human existence is duly recognised (e.g. Walsh & Frankland, 2009; Woolfe, 1996).

Nonetheless, when the research paradigm of our time is concerned with manipulating variables and *minimising* individual difference, the challenge for qualitative researchers is to ensure that they uphold the important role that values, morals and societal norms have in shaping a participant's unique perspective. The acceptance of difference and meeting the client free from assumptions of how they 'should be' are of course core attributes of our discipline. Levinas' (1969: p.47) concept of '*welcoming the Other*' captured this most fundamental ethical imperative for qualitative research. He argued that we must unequivocally accept the qualities and characteristics that constitute '*the Other*' and so their

unquestionable individuality. Their being is '*irreducibly strange*' and '*infinitely transcendent*' for we can never assume nor expect to accurately and sufficiently encapsulate or portray all that is someone else.

Such an attitude, Levinas declared, demands a '*non-allergic reaction with alterity*'; something that requires, as Cooper (2009: p.121) explained, 'a *deeply challenging willingness*' to resist any temptation to quantify or classify the client or participant we encounter. Indeed such a commitment is fundamental to counselling psychology. For this is a profession that is '*ethics-in action',* as Cooper (ibid, p.120) argued: '*our respect for our client's autonomy, our trustworthiness, our commitment to maintaining confidentiality are not just corollaries of our work – they are the essence of what we do*'. Therefore, the attitude of the researcher from conception to conclusion of a research project and their readiness to remain attuned to these professional values is pivotal.

Of course, ethical dilemmas will inevitably arise as we balance our desire to make a meaningful contribution to the discipline's knowledge-base with our responsibilities to participants. What matters most is that when they do arise, we acknowledge and address them in a manner that respects the autonomy of our participants and safeguards their wellbeing. In a research interview scenario, for instance, this must include diligently respecting the participant's account as their truth. This also means that as practitioner-researchers we must be careful not to challenge or instigate change in the way one may well seek to in a therapeutic setting. Although, Brinkman and Kvale (2008) argue that without such challenging we might merely scratch the surface of what the participants are really thinking and so impede the goal of producing meaningful research.

For example, a participant who perhaps does not like to offend, does not value his own opinion or simply wants to please, might tell me that their therapy was '*great...life-changing*'; yet all the while conveying non-verbally and in their tone of voice a sense of indifference or unease. For my research to be of any value, surely demands that I somehow address this incongruence. However, making explicit my experience of incongruence to a potentially vulnerable person may well be received as critical or exposing - and so quite possibly be

deeply affecting. Put simply, something that may be of much value in therapy could instead be harmful in a research interview setting.

A further possible dilemma arises when as researcher, I utilise practitioner skills for developing a sense of rapport and conveying empathy with the participant. The intention would be to encourage the participant to reflect upon experiences or thoughts that I consider to be of significance and relevance but which they might be reluctant to disclose because it evokes unease for them. Duncombe and Jessop (2002) refer to this as the '*commodification of rapport*'; basically cultivating a sense of affinity or empathy with the participant in order to garner more of what may be useful data.

Such ethical tensions as those described above are somewhat inevitable when trying to balance often conflicting priorities. (Brinkmann and Kvale, 2008: p.268) make this point by arguing that they '*cannot be dealt with simply by appeal to the ethical guidelines and review committees. Following Foucault (1984: p.343), 'the ethico-political choice we have to make every day is to determine which is the main danger'*. Therefore, it is incumbent for the researcher to remain reflexive and maintain an awareness of all ethical conflicts and risks throughout the research process. This is no more crucial than when conducting semi-structured interviews, which by definition mean that there is a substantial element of unscripted prompting and follow-up questions. Obviously these cannot be checked against protocols or cleared by an ethical board beforehand. It is about exercising judgment and being guided first and foremost by one's personal and professional integrity, and in particular a sense of responsibility to the participant.

Nonetheless, it is also of course essential to comply with the professional ethical standards that are in place. To this end, the guidelines followed for this research were as stipulated by the British Psychological Society in '*The Ethical Principles for Conducting Research with Human Participants*' (2009), as well as the Health and Care Professions Council's (HCPC) '*Standards of Conduct, Performance and Ethics'* (2012). Positioned as paramount in both sets of guidelines is safeguarding the wellbeing, dignity and respect of research participants. My

awareness of these responsibilities informed the design, implementation and reporting of this research. I refer below to the specific guidelines considered in this regard:

1. ***Deception**:*

   There was no requirement to withhold or disguise any details of the purpose of the research from the participants. The Participant Information Sheet (PIS) clearly explained the topic under investigation and what this practically involved for the participants. Those that expressed an interest in participating were asked to sign a consent form which included an assertion of their right to withdraw at any time. They were also issued with a copy for their own records.

2. ***Risk of harm:***

   The principle risk identified was the potential for emotional upset caused by inviting participants to reflect upon issues that they had recently explored in therapy. As well as comprehensive details of the purpose of the study, the PIS included explicit reference to this particular risk. By doing so, the intention was that those considering taking part would be furnished with the necessary information to allow them to make an informed decision. Further, since the investigation was of a recent therapy experience, the expectation was that their understanding of the potential for difficult emotions to be generated in an interview setting would be relatively good. A risk assessment was also conducted in terms of the practicalities of conducting the field work and is included in the Appendix section of this paper.

3. ***Debriefing:***

   At the end of each interview, the participants were asked to reflect upon the experience and how they felt. In the event that any upset or distress had been evoked, the opportunity to discuss and explore this with me initially was made available (participants were advised on the information sheet that I was also an accredited psychotherapist). If they needed further support, and since they were recent clients of HCS, they automatically had the option of commencing a new (free) contract (subject to the agency's standard assessment process). Participants were also supplied

with a helpline telephone number run by HCS and advised of the option of a low-cost fee-paying alternative service.

4. ***Confidentiality and anonymity:***

   It is important to be clear about the distinction between confidentiality and anonymity (Smith, Flowers & Larkin, 2009). In fact, all that can be assured to a participant in qualitative research is anonymity since to suggest that their involvement is completely confidential implies that no one else will see their data which is obviously not so. Nonetheless, protecting the participant's identity was treated with utmost importance and was secured initially by emulating the established procedures employed at HCS. On receiving a referral from practice managers, HCS practitioners are supplied with only the first name of the client and a unique identifier code. The corresponding full personal details are stored securely at HCS. I did not have direct access to contact details prior to participants agreeing to take part. Once they had, I subsequently securely stored this personal information separate from their recorded interviews, again with a unique code, identifiable only by me. It was explained to each participant (both verbally and in the consent form) that after analysis their recordings would be either destroyed or returned to them if preferred. It was explained that data referenced in all subsequent reporting would not be identifiable as theirs since aliases would be used throughout.

My primary aim in this section has been to convey how the ethical considerations transcended simply gaining authorisation to proceed from the university's Ethics Committee. It has instead been a wider and continual process of contemplating the context in which the research was prepared and conducted, as well as an awareness of the tension between my role as both researcher and practitioner. Protecting the participants as far as possible has governed my approach to the project, up to and including the final report submission.

Note1: I engaged in detailed discussions with the HCS Practice Manager (in terms of the organisation's policies and procedures for research) and proceeded only once written agreement from HCS for my research was received.

3.4.2 Assessing research validity

In this section I explain the consideration given to assessing the validity of the research. In doing so, I am mindful of having argued against adopting quantitative principles for qualitative research. Specifically, that objectivist designs run counter to the embrace of subjectivity that underpins both CoP and ET. However, this does not mean that qualitative research should not have a similarly robust intention of quality and due diligence. For both safeguarding participant wellbeing and for it to be sufficiently respected, research must be responsible, disciplined and systematic.

To this end, I have been guided by Yardley's (2000) four broad principles for quality assessment. These were written specifically for health psychology research but have been widely recognised as equally relevant and applicable to other fields of qualitative enquiry (Langdridge, 2007; Shinebourne, 2011; Smith et al, 2009). In fact they are as much about ethics, in terms of contemplating how we can most appropriately conduct our research. I address each of the principles in relation to my research in turn below:

1. ***Sensitivity to context:***

   From the outset of the project through to completion, acknowledging and understanding the context of what I have sought to explore has been pivotal to the process. Securing access to my participants involved several discussions with the Service Manager to ensure the agency was satisfied that the wellbeing of participants would be treated as paramount. It is also a key aspect of this first principle that we must be mindful of the wider socio-cultural context the participants are in as well as the specific setting of the research. To this end, I have purposely included a substantial amount of verbatim in the Analysis of Findings chapter to ensure the participants' perspectives are adequately communicated, while also providing the reader with the opportunity to validate the interpretations I have made.

2. ***Commitment and rigour:***

   This is concerned with the level of competence of the researcher including their depth of engagement with the topic, and ensuring good governance in the data collection

and analysis phases. This is a topic borne from my own work as a practitioner at HCS for three years prior to conducting this research; which I suggest reflects my personal commitment to the topic, as well as my profound respect for this client group. Moreover, to address issues of governance, I engaged in a process of iterative re-drafting of this report in collaboration with both my supervisors and peer feedback; included an audit trail of analysis; and maintained reflexive notes throughout.

3. ***Transparency and coherence:***

   These principles require showing clearly to the reader how the research process was conducted. By systematically describing each of the stages involved in the following *Method of Data Collection* section (3.5), my intention is to ensure a transparent process. By working closely with my supervisor and integrating her feedback, the aim has been to produce a coherent and logical presentation of my findings. While there is no intention to present the findings as the 'truth', there has been an objective to present them as both plausible and the most likely. Nonetheless they are of course open to challenge and any alternative conclusions would be considered a welcome contribution.

4. ***Impact and importance:***

   This final principle is deemed most important of all for Yardley since it addresses attending to the *value potential* of the study. Such an impact may be immediate or delayed but there should nonetheless be some effect from the contribution. Given the lack of ETLT research and the current economic and political appetite for evidence-based service provision, this research aims to enhance our understanding of what ETLT can offer.

3.5 Method of data collection

Having explained the theoretical and epistemological underpinnings of this research, I now proceed to describing how the actual data was collected and analysed. A principle intention in the following sections is to show how the key issues of validity and ethics described above

have guided how the research was designed, conducted and now reported. Included are details of the sampling and recruitment processes, interview design and the systematic stages of the subsequent data analysis. I begin however, by providing a description of the setting in which the research was carried out.

3.5.1 Research setting

HCS offers free (at-the-point-of-use) time-limited counselling for people affected by HIV. Funded from a combination of external sources including charitable donations and local NHS providers, the remit is to target the service predominantly at men who have sex with men (MSM). Service users are offered a contract of up to twelve fifty-minute weekly sessions. As outlined in the Introduction, during the assessment and at the end of the counselling contract, clients are asked to complete a CORE-OM form, the data from which is used to inform stakeholders of service effectiveness.

A small number of additional sessions can be considered but only in exceptional circumstances and subject to clinical discussion in supervision. Clients are also advised they can re-apply to the service, subject to a new assessment, after a three month elapsed period.

At the time of conducting this research, HCS had fifteen practitioners of whom seven were trained, and identified themselves, as existential therapists. As a charity, all therapists are employed on a voluntary basis and most are in clinical placement. Where this is so, however, placement therapists are at an advanced stage of their training, having accrued a minimum of two hundred and fifty client contact hours before joining. In terms of the therapists for the current research participants, all were on the third or fourth year of a doctoral counselling psychology trainee programme and were already qualified to a minimum of diploma level.

3.5.2 Research preparation and quality assurance

Intended as part of the preparation for the actual research, I conducted a pilot in which I recruited and interviewed one participant. I subsequently analysed the data and submitted the resultant report to my supervisors for assessment. Essentially the purpose of this stage

was to ensure an appropriate level of overall quality for the research by identifying and addressing problems or difficulties encountered.

Before conducting the pilot, however, and mindful of the sensitivity of the material I was inviting people to share, I decided to first test my research questions on a colleague who had herself previously had ETLT (as a client). Since the subsequent actual pilot interview involved a real user of the service, this 'pre-pilot' exercise was intended to help further safeguard the participants' wellbeing.

Once the modifications from the pre-pilot process had been integrated, I proceeded to the actual pilot, interviewing one participant recruited from HSC who had very recently completed a twelve-week therapy contract with an existential practitioner. After transcribing this initial interview and assessing the content with my supervisor based upon initial analysis, it was agreed that there was sufficient depth and coverage in this interview for it to be included as the first of the 'actual' interviews and that I should therefore proceed with the main research.

In the following sections I define both the inclusion criteria and the recruitment process for the participants.

3.5.3 Participant inclusion criteria

As an idiographic study, the selection of participants was purposive and homogeneous (please see *Table 3.1* for the profile of all participants in this study). Specifically, prospective participants were required to have recently completed twelve weeks of ETLT, as a first module. They would also be required to agree to attend a follow-up interview at a later date. The demographic profile of the research was therefore largely determined by those who volunteered to participate, providing they met the aforementioned criteria.

3.5.4 Recruitment process

I negotiated a process with the HCS manager in which I could directly contact the existential practitioners and ask each of them if they would consider making available to their ending

clients my *Participant Information Sheet* (PIS) which explained my research. Obtaining agreement to do this enabled me to contact the practitioners by email and in person to canvass them for their support. Emphasising the lack of existential CoP research and also assuring them of their own anonymity emerged as key factors in securing most of their agreements to assist. Six of the seven I contacted readily pledged their support and intention to distribute my PIS to ending clients.

Of those furnished with the PIS (number unknown), five contacted me expressing interest in taking part. At the point of speaking to each prospective participant by telephone, I asked them to confirm the following inclusion criteria:

1. *number of sessions attended*
2. *that this was the first (twelve-week) module of their current therapy*
3. *agreement to attend two interviews: one as soon as possible after ending therapy and a follow-up interview twelve weeks later*

It was particularly important to make explicit from the outset the intention for a follow-up interview and the reason for it in order to avoid conveying at a later point any impression that they had somehow given 'wrong' or insufficient answers in the initial interview; and so risking reframing or changing what was said initially.

Only one of the five did not proceed beyond this recruitment stage; on the basis that his therapy contract had been punctuated by significant breaks as well as being reluctant to commit to attending the follow-up interview. For those who met all criteria, I emailed them confirmation of the information they had supplied by telephone, as well as the agreed arrangements for the initial interview.

Table 3.1 below details the principle profile characteristics of my research participants. Most of this information was obtained in the initial contact stages but also some (i.e. ethnicity and HIV status) was obtained during the first interview. All self-identified as gay. Three were diagnosed HIV positive while one had not but was concerned about his risk of infection. Finally all had had therapy before, prior to this experience, in different settings.

Table 3.1 Profiles of the participants

Alias	Gender	Age	Ethnicity	HIV status	Sessions attended
John (NLP001)	male	38	White Irish	positive (<1yr)	12
Oliver (NLP002)	male	34	White British	unknown	12
Jawaad (NLP003)	male	43	Zimbabwean/British	positive (>2yrs)	12
Michael (NLP004)	male	36	White British	positive (>3yrs)	12

I outline below the interview design and the reasoning behind the decisions taken.

3.5.5 Interview design

In line with IPA principles, I conducted semi-structured interviews with the intention of facilitating a participant-led exploration of their experience (the actual interview questions are detailed in *Appendices v*/*vi*). I conducted two interviews with each participant: the first within one week of their final session of therapy, and the 'follow-up' interview twelve weeks later. Such a two-stage interview design is entirely compatible with IPA principles (e.g. see Smith, 1994). While praised as '*bolder*' and '*more adventurous*' by Smith et al. (2009: p.52), they also acknowledge that the subsequent analysis can be more challenging. The opportunity and potential afforded by a two interview design I considered to outweigh such concerns, something which I will explain further below.

In terms of the second or 'follow-up' interviews, their principle purpose was to provide both the participants and me the opportunity to clarify and elaborate on reflections made in the initial interview. Being relatively inexperienced as an IPA researcher, this afforded me the opportunity to read through the first interview transcripts and highlight comments that may have deserved deeper exploration or clarification at the time but that, for example, I may have simply missed. Indeed, Flowers (2008: p.25) refers to this being an issue for any

interviewer by arguing that the '*cognitive load of remembering what the participant has said in order to probe and funnel for more information*' means that the likelihood of such lost opportunities can be high.

In terms of the interview timings, I decided to conduct the initial interviews in the immediate days after the counselling contracts had ended for two main reasons:

1. I assumed there would be a higher likelihood of securing involvement from service users while their experience was very recent

2. While the experience under investigation was recent, the potential for '*participant attrition*', or memory erosion, could reasonably be considered to be minimised (Flowers, 2008)

Moreover, I purposely chose the lapsed time period of twelve weeks between interviews for the following reasons:

1. Users of the service can re-apply for a further course of sessions after twelve weeks have elapsed from the end of their current contract. As such it was important that any follow-up was conducted before a possible new contract began

2. This twelve-week elapsed period between therapy contracts was designed by HCS for the purpose of affording clients time to integrate any therapeutic outcomes into their lives - and so assess if any further therapy was needed. I considered it therefore appropriate to allow for any such process to occur. In doing so I could also establish if the participants had reached a decision to re-apply, or had instead concluded that the therapy received was sufficient for meeting their needs and objectives

With regards duration, the initial interviews lasted between sixty and ninety minutes, and the follow-ups, between fifty and sixty minutes. The subsequent analysis of the data for each participant required careful management and systematic working; the associated process and procedures followed are explained in the following section.

3.5.6 Data analysis

Before presenting the research findings in the following chapter, I address below the decisions made in terms of how to analyse data from two interviews for each participant.

One key issue that can arise with a design that involves more than one interview is that it can become increasingly researcher-led, and particularly so in the subsequent, or follow-up, interview(s). Flowers (2008: p.26) warned of this intrinsic risk in multiple interview designs by arguing that '*the interaction may become more broadly 'interpretative'...as social dynamics and 'response bias' potentially amplify or reify analyst's interpretations*'. In other words, the researcher's emerging conclusions from the initial interview influence and shape the follow-up interview, including the questions asked. As such, had I decided to fully analyse first interview transcripts *before* conducting the follow-up interviews; the potential for the latter to be a researcher-centric and deductive process would be increased. Given I am principally reporting and analysing experiential accounts, this would clearly compromise a fundamental aspect of my research aims.

For this reason, after transcribing the initial interview recording I read through the full transcript once only, highlighting areas which I felt would benefit from inviting the participant more time to expand upon or clarify. This also afforded me the opportunity to compensate for any lapses in both my interview technique and the participants' attention in the first interview. To have gone for a 'harder' design of a full analysis of the first text prior to the second interview would have firmly positioned the research as principally analyst-led. Therefore, at the beginning of the follow-up interviews, the participants were simply asked if they had any further thoughts on their experience that they would like to add to what they had said previously. All were also asked again if they felt their objectives had been achieved from the therapy – the purpose of repeating this from the initial interview was to explore if any initial assessment of outcome endured. Once they had done so, I then referred to the specific areas that I sought clarification or expansion on (see *Appendix vi* for a specific example of this).

In terms of the actual data analysis process and as a result of the approach outlined above, each participant's data was regarded as effectively a single 'mega interview' (although there was an element of cross-referencing when I was seeking clarifications). A key advantage of this was simplicity in terms of conducting the analysis and indeed in the writing-up of this report. That said, each transcript was analysed separately initially in order to capture the uniqueness of each account and also to ensure that the participant-led aspect of the research was protected as much as possible. Equally so, in terms of presenting data extracts in the Analysis of Findings (Chapter 4), I do specify which wave of collection it comes from, commenting and drawing comparisons wherever relevant. Below I describe the specific stages of analysis that were conducted.

Initial stages of analysis

Each participant was initially assigned a unique identifier code, as detailed in *Table 3.1* and the audio recordings of all interviews were encrypted and stored on my password-protected computer. I subsequently transcribed these recordings into a Microsoft Excel spreadsheet; identifying myself speaking as '*NLx*' and the participant as '*Px*' (where *x* denotes the line number).

After transcribing the interview recordings I followed the guidelines for data analysis as recommended by Smith, Flowers and Larkin (2009). This involved first listening to the interview recording while re-reading the transcript and noting my initial thoughts and impressions in my reflexive diary. I included at this stage recollections from the interview; such as how I was feeling at the time of meeting the participant; any strong emotions I remember experiencing in response to what was being said; and how I experienced the person. Throughout the analysis process, I also added to my reflexive diary any free associated thoughts that were emerging for me as I read and commented upon the text. This was an important step in reducing 'noise' around the data. In particular, it helped me in bracketing any ideas and hunches and so maintain an appropriate focus. For the initial interview transcripts, in this first read-through step, I highlighted the areas that would benefit from re-visiting in the follow-up interview, making a note of these accordingly.

For all transcripts, during the subsequent read-throughs, I made notes as I proceeded in columns to the right of the text. There were three categories of notes: *descriptive* (describing *what* was being said as it appeared), *linguistic* (focus upon use of language – tone, pauses, metaphors etc.) and here I included my observations such as how I felt something was said. For ease of space and subsequent analysis, I decided to combine these two aspects in the one column.

The final category was my *interpretative* comments which I attributed on a further full transcript reading. This time I engaged in a more interrogative level by shifting away from the explicit text to a more conceptual consideration of what was being *implicitly* revealed. I included notes on how I understood the participant's reflection both as a component and where relevant within their wider context, invoking the hermeneutic circle. This was a tentative process guided by the principle that any such interpretations must be stimulated by and tied to the text (Smith et al, 2009). In *Appendix vii* I show an example excerpt from an interview transcript showing these stages of analysis.

Identifying the emergent themes

I now moved on to developing the emergent themes and the guiding principle here was that they should capture my understanding of the experience. That is, and again mindful of the double hermeneutic process, they should constitute a reflection of my interpretation of the participants' thoughts. The themes were notated on the left-hand margin of each of the transcripts and from which I created a chronological list of all emergent themes; working through the list sequentially identifying any connections, similarities or duplications across the themes list.

I then grouped together conceptually similar thoughts and emergent themes and surveyed these through utilizing the *polarization process* which looks for and groups together themes that have polar opposites to one another. Some emergent themes were clearly similar or related and so were readily grouped together, or absorbed into stronger but similar themes. Frequency was also taken into account as a possible indicator of their importance to the participant. It is worth noting that this abstraction process was in some important ways made easier for me by there being a chronological structure to my interview questions. That is,

there were three distinct temporal contexts being explored: entering, during and ending therapy, so there was already a logical grouping in place to a large extent.

I included an additional stage at this point to highlight where I had specifically asked in the follow-up interview for a participant to clarify upon a particular point from the first interview. I cross-referred between the transcripts to establish if there was more detail offered to what had been initially said and also if there were any distinct differences in perspective conveyed between the two interviews. I conducted this within-participant step of analysis subsequent to the individual process for all transcripts in order to further manage the increased analyst-led nature of follow-up interviews.

The next key stage, and as described below, was to identify patterns and commonalities between the participants.

Cross case analysis

This stage involved looking across the emergent themes from each participant; an involved process of grouping, cataloguing and also re-naming where necessary. Again, the frequency of occurrence between cases was taken into account as a tentative identifier of what the super-ordinate themes would be. As stated previously, however, the most logical structure was to stick to the stages of the therapeutic process (beginning therapy, during therapy and the ending). Nonetheless, by examining across cases for the recurrence of themes and following Smith et al.'s (2009) suggestion that a super-ordinate theme should be evident in at least a third of the interview, added a further element of validity to the findings. This was an iterative exercise in which refinements continued up to and including the write-up of the report.

In the following chapter, I discuss the results of this analysis and present in turn each of the super-ordinate themes and associated subordinate themes. Before doing so, however, I offer some further reflections below on the reflexive aspect of the analysis process.

3.6 Reflexive engagement with the research

Kasket (2012) reminds us of the importance of attending to both epistemological and methodological reflexivity when engaged in qualitative research. From an epistemological perspective, this is about acknowledging that alternative research methods could have been utilised and so produced different results to that here. In the preceding sections in this chapter, I have sought to demonstrate my acknowledgement of this. I adopted IPA as my research method because it fitted best with what was being explored and, crucially, it reflected my personal vantage point. However, this does not imply any notion of superiority over other research methods. Rather, this is about research integrity in terms of appropriateness to the research question and my embrace of critical realism and hermeneutic phenomenology.

In terms of methodological reflexivity, IPA requires the researcher to be accountable for their reflexive stance as they become immersed in the process. That is, by conducting and analysing semi-structured interviews from a hermeneutic vantage point means by definition I brought myself and my lived experience to the process. Working from the position, as has been emphasised in this paper, that we are *always* in-relation, the researcher inevitably impacts upon what emerges and of course their interpretative process is a key component of this. So my questions and prompts, my way of being with the participants, how together we were relationally, and what I made of what was being conveyed to me, collectively shaped what I subsequently have reported here.

Nonetheless, it was of fundamental importance that I remained close to the actual experiential accounts. As the researcher, my primary function was essentially a conduit or facilitator of the participants' reflections. Shaw (2001) warned of the importance of remaining aware of this otherwise the researcher risks losing sight of what is actually being conveyed, distracted by their own narrative. Being mindful of this possibility throughout and while entirely possible that someone else conducting this research would produce a variance of my findings, it is my view that I have reported what would generally be accepted as a reasonable reflection of the experiential accounts.

By way of safeguarding against being distracted by my personal narrative as Shaw warns, there are bias-reduction techniques which could be employed such as Heron's *Co-operative Inquiry* model (1996). This recommends relaying preliminary findings to the participant to allow them to challenge or confirm before they are finally reported. While I did not formally adopt this or any such strategy, by seeking clarification and elaboration from the participants in the follow-up interviews, meant that this was at least partially addressed. Of course, to a large extent this depended on that which I deemed might require clarification in the follow-ups and therefore is researcher-led in this regard but I sought to manage this by requesting clarifications in a sufficiently non-directive way.

While I was analysing the research I maintained a diary in which I reflected upon my emerging thought processes, feelings and emotions as I interacted with the data, again for the principle purpose of containing and managing how this may contribute to the shape of my findings. I approached this aspect of the interviews as all others, with a genuine curiosity about what was emerging. For example I was curious about what particularly captured my attention or interested me most and why. I was especially mindful of my embodied reaction to participant reflections about their unease with sexuality and in their fearing persecution or discrimination. I observed at times feeling anger and profound sadness, reflecting my personal distaste for any such stigmatising or discrimination. The iterative process demanded of IPA together with the reflexive diary helped me greatly in observing, owning and containing these felt responses, and ensuring I fairly reflected the participants' experiential accounts, as well as my interpretation of them.

In the following chapter I present my findings. It is intended that my awareness of the reflexive issues explored in this section will be evident and, most importantly, that the participants' experiences are adequately and respectfully reported.

4. Analysis of Findings

As stated in the Introduction of this study, I am seeking to convey an interpretative account of the entire therapeutic endeavour from the unique perspectives of each participant and specifically, within the context of identifying commonalities in their experiences. Mindful of the centrality of temporality to the therapeutic process, I present my major themes below as being analogous to a journey. Engaging in a therapeutic process involves in some way travelling from one point in time and circumstance, through to another. Ideally this transition will be to an improved state of wellbeing but in any case, it will certainly be towards something else. Presenting in this way made sense to me for a number of reasons, which I will explain below before I proceed to the actual findings.

Firstly and perhaps most evidently, since the word *journey* implies a moving from one place to another, it can be rather useful to contemplate the therapy process in this way given there is typically an intention to somehow move from one way of being towards another. As part of this, I myself was immersed in a journey - an exploration of my participants lived experiences and how I experienced these reflections. In other words, how the double hermeneutic of the interpretative process informed and so transformed me. Primarily, however, since there was a chronological nature to my research questions in terms of exploring what precipitated the decision to enter therapy, then the actual experience of the sessions and contract, and finally what the participants departed the process with, the journey metaphor seemed to be particularly relevant.

The three major themes and associated subordinate themes derived from my analysis are illustrated in *Table 4.1* below. In the first theme, I have sought to capture the common experiences of the participants as they made their decision to begin therapy; preoccupations, concerns and also their hopes at they started the process. As I then moved towards looking at what actually happened during the therapy; the therapeutic relationship, the specifically time-limited setting and what existential therapy looks like in practice. Finally, the logical

conclusion to a journey is arriving at a destination, which felt as important an area to understand. That is, what would the participants take from their experience of existential time-limited therapy? Perhaps most crucial of all, did they reach where they wanted, or needed, to get to?

Table 4.1 ***Major themes and their associated subordinate themes***

1. Beginning a time-limited existential journey	
1.1	A quest for acceptance
1.2	Obstacles en route to trust
1.3	A need for therapeutic substance over style
2. A time-limited existential exploration	
2.1	A meaning-revealing journey
2.2	How a relational alliance is the conduit for change
2.3	The opportunity of the time-limited setting
3. Leaving a time-limited existential journey	
3.1	Purposeful living from adversity
3.2	The value in taking stock
3.3	The beginning in the ending

With these principle aims for my presentation of findings, I offer below a detailed elaboration of each of the identified major and subordinate themes.

4.1 Major theme 1: Beginning a time-limited existential journey

The essence of this major theme is the *why* behind the decision to begin therapy at this particular time in each of the participants' lives. What I was particularly interested in was trying to understand what they actually wanted from it and of any anxieties they had as they approached it. Also, since I am specifically exploring existential therapy, I wondered if the orientation of the therapist would emerge as a consideration for the participants. Collectively, by conveying key aspects of the presenting issues and objectives, common and particular apprehensions about the practitioners and their orientation, the following subordinate

themes are intended to offer a reflection of what each participant embodied as they began their unique journeys.

4.1.1 Subordinate-theme: A quest for acceptance

This first subordinate theme intends to convey the reported reasons for beginning this particular therapy at this particular point in their lives. Perhaps not surprisingly, all participants described being in search of something they had either lost or never had but certainly valued deeply and so it was from this that led to me the idea of it being a *quest.* During the interviews and throughout the iterative analysis, a persistent and clear concern evident in all accounts was the fear or assumption of judgement. '*How am I perceived by others?*' was a fundamental question emerging from all transcripts, with the implicit profound anxiety being that they would be judged unfavourably and so ultimately rejected. They all conveyed a sense of shame and guilt associated with aspects of their way of being and an associated self-imposed degree of isolation. When asked what they wanted from this therapy, the salient message I heard was that all participants wanted and needed a space where they would not feel judged, where they felt understood and where their sense of self and way of being in the world was acknowledged and respected. Indeed, what was desired from the therapy was reflective of what they yearned for in their lives – acceptance. In the following interview extracts, I aim to show how this was evident across the individual accounts.

Since HCS is a counselling service principally and predominantly for men who have sex with men and somehow affected by HIV, each of the participants presented with issues that were correlated to this, although with notably varying levels of perceived relevance to their current situation. Only John, very recently diagnosed as HIV positive, wanted to directly address living with the virus and how this was impacting him in his therapy. He had been unwittingly infected by his boyfriend, a brief relationship which had now ended. In the following extract, he describes how his greatest dread had now been realised and specifically how this triggered for him a profound fear of judgement by his family and the wider society:

> *I mean my biggest fear had come to life...and it was a fear that had been programmed into me from such a young age...I remember seeing the ads when going to the*

> *movies...it was just so ingrained in, you know, what being gay was...and the tragedy of it...this tragedy of being a gay person. You'll party hard and you'll get HIV and what that was and you'll die. And I just felt like such a cliché. Erm for me it represented punishment for a kinda hedonistic lifestyle and oh judgment and fear of your own sexual desires erm cos there was this huge consequence to it. And so there is a conflict the whole time cos you still have that desire but then there is the guilt around that. There's just a lot of stuff going on around it. Erm and I just felt I was a huge letdown...you know telling my mum, the idea of that...you know it's her worst fear come true.* (II38-40)

John considered his positive diagnosis to be a consequence, perhaps even inevitability, of his sexuality as much as his sexual behaviour. To be gay, he had deduced, meant you would eventually pay dearly for improper and irresponsible sexual proclivities and lifestyle choices. He was holding an intense disappointment and condemnation of himself for subscribing to the stereotype of what gay men do and that had ignited in him an ingrained potent fear of impending and inevitable doom. Within this context, his HIV positive diagnosis served as further validation to John of an already well-established internalized prejudice he had about his sexuality. Shame was a fundamental aspect of his way of being, how he related to himself and engaged with the world, and this had now been acutely intensified by his diagnosis.

John therefore began his therapy in a pronounced state of crisis, fearful of what this new reality meant for him, as well as for his family and friends. Holding a profound sense of actual and feared loss: his relationship had ended, his assumed physical health was compromised; he anticipated rejection by loved ones, a punitive judgement from society, potential loss of career and financial stability, and ultimately, John feared for his life. He was clear on his principle objective from the therapy:

> *Acceptance. Erm....I knew that cos it's such a...it's a definite diagnosis, it's not gonna change so I knew that my only way of survival was to accept it. I can't change it. But that's not the way I felt, it was just incomprehensible to accept.* (II21)

The stakes were high for John. Therapy had to facilitate a new path for him in terms of his relationship to both the diagnosis and to himself - one that was entirely less punitive.

The embodied shame associated with his sexuality and so apparent in John's narrative was similarly evident for Oliver as he told me why he approached HCS. For him, his struggle was principally manifested in cyclical bouts of depression. In the following extract, Oliver explains how a particularly intense period of depression served as a catalyst for him to decide to finally address why he was experiencing such low moods**:**

> *I was feeling...not suicidal...but I was having suicidal thoughts and I thought... I know that that's not right and I should look at it and if there's something really wrong then I need to confront it, I need to talk to someone*. (II15)

He spoke of his depression as part of a pattern of behaviour which he hoped that by understanding the underlying causal reasons, he may be able to break. While appreciating there can certainly be a distinction between 'having suicidal thoughts' and 'being suicidal', the above quote revealed for me a tension for Oliver between making explicit the depth and intensity of his depression and at the same time his reluctance to be labelled or pathologised. Indeed on a number of occasions in his interviews, Oliver made reference to what he considered to be society's stigmatising view of mental illness. When looked at from a more holistic level of his general narrative, Oliver expected how he was would be in some way punitively categorised.

Oliver regularly frequented men-only sauna for anonymous sexual encounters and self-identified as a sex addict. While he assumed himself to be HIV negative, he worried about the potentially elevated risk of infection that his behaviour was exposing him to. He related the addiction and his relationship with his sexuality to a fear of how he may be perceived by his parents, again bringing to the fore anxieties around judgment and rejection:

> *I have never really come out to my parents... So this is kind of a big thing and I think if I contracted HIV you know I would rather not have to tell them I picked it up at a sauna. It's a big enough deal that I have to tell them I am gay...it's not how I want to be thought of. I think I want a healthier lifestyle where I have a partner and friends and don't do so much of that sort of thing.* (FU92-3)

Of course one must be careful not to unequivocally assume a problematic correlation between someone's desire for casual sexual encounters and a struggle with sexuality.

However, it certainly seemed that these sauna rendezvous represented a segregation of Oliver's sexuality from the rest of his life. I suggest that this also precipitated a projection of critical judgement by his parents if he were to disclose to them that he was gay. Oliver's comments here reveal the profound isolation he was immersed in. Yearning for an integrated and meaningful relationship network, he was instead trapped by a deep unease with his sexuality and paralysed by the fear of rejection. Oliver considered himself to be unacceptable, and therefore so would others. So as with John, we can see an ongoing struggle and damaging conflict for this participant between his innate sexual needs and the consequential shame indicative of an internalized unease with his sexuality**.**

I experienced Oliver as sunken and resigned to life as he sat in his chair across from me in both our interviews together. Long sighs punctuated his dialogue which he typically delivered in a slow and monotonous manner. I observed in myself sometimes quite pronounced feelings of hopelessness as we conversed. His sense of isolation and craving for meaningful relating to others, evident in the above extract, could surely only be achieved by him finding a new way of relating to himself. This was at least his implicit intention in finally deciding to confront in therapy the source of his depression.

While for John and Oliver there appeared principally fears of judgment from others, Jawaad described having experienced actual and blatant prejudice in his workplace, telling me that his employers '*knew I was HIV positive. They knew I was gay. I have no doubt in my mind there was discrimination going on there*' (II22). The consequent emotional toll had driven him to the point of breakdown:

> *I don't know what you are supposed to be feeling when you are having a nervous breakdown but I would be having panic attacks just sitting watching TV *pause* Yes, almost struggling to breathe, sweating palms. I unfortunately decided to take the wrong route and got involved with somebody who was *...smile* using. So...started taking Class A's and it was only useful because I spent most of Friday night and Saturday night off this planet. (*II35-6)

Jawaad's drug use was a means of escape from his despair. He felt and was told that he was failing in his job and was being essentially punished for his sexuality (perhaps in some ways

akin to John's experience of his positive diagnosis). Panic attacks while even at home, imply an almost constant sense of being under attack. Jawaad embodied this hostility and to be with himself had become increasingly difficult to bear. His solution was an intended, albeit temporary, annihilation of self to alleviate the pain. As with Oliver, Jawaad engaged in anonymous sexual encounters and which he considered to be indicative of low self-esteem:

> *The other thing that goes with that is anonymous sex, there was an awful lot of that. An awful lot...I only took drugs if I was going to have sex. I needed the sex to feel validated.* (II170-1)

Again like Oliver, the sexual encounters appeared to be for Jawaad less about gratification of sexual desire and instead seemed to be a strategy to feel wanted and accepted; an intended antidote to the persistent pain of rejection and alienation. Through these sexual encounters he was validating his being, albeit in a way that did not lead to any satisfaction or wellbeing. Certainly the implication was that he felt invalid or less than, probably triggered or hastened by the persecution in his workplace.

Early in our first interview it became readily evident to me that Jawaad would have much to say about his therapy experience. He seemed to relish the opportunity afforded by these interviews. From a linguistic perspective, his delivery in itself was revealing. In the extracts above we can see where he would sometimes employ pauses and repeat words which I experienced as a means of emphasis. I also recall wondering if I was being somehow tested in these early stages of our initial interview, maybe assessing if I could be trusted to engage with his story free from judgement.

Michael also described beginning his therapy in response to a sense of imminent breakdown, but which in his case had resulted from a recent relationship ending and a subsequent bout of intense depression. In alluding to his despair, Michael evoked a powerfully vivid description of his experience:

> *Desperation. It's utter sadness, erm total lack of control over emotion and just an 'oh God!'... a desperate howl...it's almost like a guttural howl for help. Erm and yet everything is kind of grey, everything is almost like static, it's just a nothingness and*

> *you don't think anyone can hear what you're going through, or that anybody cares about what you are going through or how you feel. Complete isolation and not having the ability to find a way out of it.* (Michael II182)

The explicit message here from Michael was that when immersed in such despair he concludes that no one understands him and so he is completely alone. This was incidentally a striking contrast to his jovial demeanour in the research interviews. The isolation Michael refers to above is a felt sense in the midst of his depression and of course different from aloneness but in fact he also went on to speak of how he would physically isolate by locking himself away for entire weekends in his apartment and whenever not at work.

Similar to Oliver and Jawaad, Michael indicated a compromised level of self-care (in his case with excessive drinking), again indicative of low self-worth. He conveyed his perceived inability to maintain an enduring intimate relationship which he attributed to long-standing issues with poor self-esteem. He told me he had difficulty asserting his needs to others which he wanted to address in his therapy although he was already clear on its origin:

> *Well the lack of self-esteem and poor self-image comes from way way back when I was a kid. Erm so that's kinda ingrained in me really (from) family, school, teachers... Yeah. Erm to the point now where I can't even bear (to) have a mirror in my house. I can't abide my own reflection, I hate photographs of me, that kind of thing. Erm and in terms of assertiveness that goes with relationships be it work...friendships...erm I ...I...tend to have difficulty in saying no *smiles** (Michael II49-51)

Michael's lack of assertiveness in relationships, and an eagerness to please again conveyed an underlying desire to be accepted by others. As with the other three participants, this seemed to be directly reflective of low self-esteem. His tendency to blame himself for relationship failures triggered a spiral of shame and self-loathing.

Within the context of Michael's narrative of low self-worth, I wondered if the self-imposed physical isolation from others, as well as betraying a cripplingly low self-image, was also somehow a pre-emptive strike - *I am unacceptable to myself and so also to others, therefore I will be rejected*. From his therapy, he said he wanted to acquire coping strategies to address

the bouts of depression so that he could '*find ways of stopping it or avoiding it or if it does happen again finding ways to suppress it or...I don't know*' (II35).

Collectively then for my participants at the start of their individual journeys, a common thread of profound feelings of shame, low self-worth and a consequent lack of self-care emerged. They were all in some fundamental way essentially estranged from themselves and portrayed acute feelings of loneliness and isolation. Invariably the answer they reached to the underlying question of '*how am I thought of by others?*' was that their way of being in the world meant that in fundamental areas of their lives they faced likely rejection and isolation. Each participant was living with an inner conflict and an at best ambivalent relationship with their sexuality, as well as unease in their more general relating with others. As they began this process, all therefore wanted and needed to experience in the therapy a judgment-free and meaningful human interaction so as to at least begin their quest for acceptance by others and by self.

4.1.2 Subordinate-theme: Obstacles en route to trust

Given the emergent anxiety around judgment and the common objective of acceptance by self and by others as reported in the previous subordinate theme, it might well be expected that such anxieties would permeate anticipating how the therapist would engage and interact. It seems reasonable to contend here that we know the establishment of trust as being a key factor in developing a working therapeutic alliance. However perhaps this could be no more relevant a prerequisite given the presenting issues and context of these participants. Achieving and experiencing trust in this setting was intrinsically linked with the goal of experiencing a sense of acceptance in their lives. That is, each would have to experience trust in both the therapy process and the therapist in order to engage in a meaningful exploration of their relationship with themselves and others.

Therefore, in terms of the title of this subordinate theme and in keeping with the journey analogy, *en route* denotes moving towards a destination. While the ultimate goal for the participants was acceptance, trust had to be arrived at first as a conduit for all else that could follow. Further, as well as being a prerequisite to therapeutic work, the co-creating and

experiencing of a trusting environment could well be a potent therapeutic outcome in itself. There were, however, emergent specific concerns correlated with the fear of judgment that were identified as *obstacles* or challenges to trusting the therapist and so feeling safe to engage in the process. In the following extracts, I will demonstrate how explicit concerns about gender, cultural and assumed sexuality differences, as well as implicit anxieties around personality discord were all initially experienced as such obstacles to trusting the therapist.

During the assessment interview at HCS, prospective clients are asked if they have a preference in terms of the gender of their counsellor. Only John indicated to the assessor that he had – that he wanted to see a male counsellor. Specifically, his fear was that a female therapist would be more likely to reach presumptive conclusions as to how his sexual behaviour had effectively resulted in his positive HIV diagnosis:

> *I would have felt uncomfortable talking to a woman about that (HIV diagnosis). I just felt...that I needed to...that I would be more at ease...yeah...around a man. How I got it, why I got it, my sexual history or sexual past...might be...you know...on a ...on a logical level probably unfounded feeling that I might be judged but that's just how naturally I felt more comfortable with a man.* (II7)

Again, the anxiety and fear of judgement and disapproval is made explicit. His concern was that a female therapist would be more inclined to effectively revert to making stereotypical assumptions when considering his way of life since she could not know what it feels like to be a man and in particular a gay man.

John was conveying here the value and importance that he attached to the therapy. This very much mattered and was an opportunity that he had to embrace but to do so he knew that he had to feel comfortable with the therapist. Being allocated a male then, afforded him the sense of commonality which he anticipated would contribute to the early establishment of trust in his therapeutic relationship. John was clear that he must minimise the potential blockers and maximise the likelihood of trust and non-judgement in order to facilitate a ready engagement in his crisis. This was not about rationalising or challenging the assumptions he knew he may well be making. There was not time for that.

At our follow-up interview, on further exploration of how it may be different with a female counsellor, John elaborated further on his view of gender-specific attitudes to sexual behaviour and which were reflective of his own unease:

> *It's just that it wouldn't feel right (with a woman). It's not something I would do with my sisters. It's not something I would do with my mum. It's very intimate relationships that I have with women, but there is respect there in a way. There is joking, of course, but I've never really, even with girlfriends, I've never really...like there was a female flatmate and in some ways I kind of used her as a control to stop me from bringing random guys home. It would only be when she was away then I might have someone over.* (FU57)

This extract offers a revealing insight into John's general narrative and punitive view of himself. He used his female flatmate's presence as a restraint, effectively bequeathing responsibility for managing his sexual behaviour externally. For John, women have a more respectable relationship with sex since for them it is an aspect of a stable monogamous relationship. The implication here is that men, therefore, will be more inclined to be promiscuous and paradoxically to his logic of wanting a male, perhaps less trustworthy. Further, in describing the depth of his relationships with key women in his life as '*very intimate'*, it seemed particularly notable that John *qualified* this in saying '*but there is respect*'. I have wondered, for example, if this suggested that these concepts were on some level mutually exclusive or at least not familiar correlates in his worldview.

Again, then, John is revealing the deep carried shame in his narrative – he hides his sexual behaviour from females in his life that he assumes will judge him unfavourably. In revealing and projecting such a punitive and critical view of himself and stereotyping of genders, in his state of acute emotional pain and crisis, being assigned a female therapist would have been perhaps too challenging for John. Of course, there is potential for therapeutic gain if experienced but my sense of John was that this would have been an unassailable obstacle to his process.

Michael, in referring to similar concerns in terms of gender, also wanted a male therapist but unlike John felt unable to state this preference at his assessment interview. When the

therapist subsequently allocated to him was female, he was concerned that he would be constrained in his disclosures and wondered if it would be at all possible for someone with such a fundamentally different context to his would be able to understand him:

> *Yes that I may not be able to talk candidly about sex but that's me projecting that onto...but because she is a woman she may not understand as well as say a gay male counsellor.* (FU61)

The need for the participant's way of being in the world to be understood from the earliest opportunity in the therapy is apparent. Specifically, how that could be fundamentally different from a female and, further, a (presumed) heterosexual one, revealed Michael's fear of judgment by his therapist, as well as the fear of simply not being understood. He expanded on this and contemplated the value of having a therapist with the same sexuality as well as gender:

> *Erm I suppose if I rather than that whole going in feeling awkward, I suppose if you go in knowing that they're gay half that battle is already won you know what I mean? And I suppose there is and I know maybe there shouldn't be but there is that whole thing about meeting people erm fresh from the very beginning. You do pass some certain judgments and there is some certain level of expectation and acceptance and everything and if you know certain aspects and qualities from the outset then half the battle is won. You don't need to prove or feel the need to explain, you know what I mean?* (FU63)

By querying how a heterosexual female will understand and relate to his male, and specifically gay male, context, Michael is mindful that some such assumptions of his may be misplaced but that they are nonetheless present and as such potential blockers to meaningful work. By twice using the metaphor of '*going into battle'* evoked for me notions of an expected conflict or an assumption of hostilities and thus the need for connection. Being understood and not rejected by the therapist would be, as in life, a struggle. Equally striking was the perceived need to '*explain*' and '*prove*' evoked for me a courtroom metaphor of him somehow being on trial since his anxiety is that he will find himself in a hostile, indeed accusatory, situation in which he has to defend himself against punitive judgement. This offers us a glimpse of Michael's expectation and experience of being in relationship with the women in his life.

Michael presented himself in our interviews as someone with an acute sense of urgency in all that he does. Indeed he made explicit on a number of occasions in the interviews his loathing of 'wasting time'. As he makes clear in the above extract, he envisaged that a male therapist disclosing his (same) sexuality to him would considerably help facilitate a more expedient focus and understanding on his issues being brought – they could hit the ground running. Therefore, if we consider this specific opinion in his wider worldview suggests at least an awareness of the potential constraints of a time-limited setting as he began his therapy. It was certainly essential and of concern to him that he could feel confident from the earliest stages that he was being understood and that he would be able to explore sensitive topics, again free from judgement.

Jawaad had entered counselling feeling persecuted in his workplace because he was gay and also because he was HIV positive. It was crucial for him that in the counselling his predicament was acknowledged and understood. As well as concurring with Michael in a preference for a gay male counsellor, and also similarly nonetheless not stating any preferences at the time of assessment, Jawaad reflected upon how cultural and specifically language differences with his counsellor led him to speculate on her adequately comprehending him. In the following extract he explains how in the initial sessions and beyond hearing her strong foreign accent triggered strong doubts that this would be possible:

> *This counsellor wasn't English. Which for me raised all kinds of questions about does she even understand what I am saying? And it became apparent later that she did, but because in those first few weeks there was a lot of nodding I just wondered 'are you on the same page as me?' When you are in a bad place you do bad things and one of those bad things was I would play-up using English phrases. Like 'cut from the same cloth' type thing and if you were not English you would be wondering what that was about because you would be thinking 'cloth...cut...?' And so I would try these things out and I would get this kind of nodding and I would think 'do you actually understand a word of what I am talking about?'* (II61/2)

Jawaad's edifying description of setting comprehension tests for his counsellor at the beginning of their work together reveals how potent his need to experience empathy and connection was. Jawaad's worldview was to assume the worst when in relationship to others and this is evident here. His wariness as well as being indicative of his anxiety and need for a

meaningful interaction, reflected an inherent assumption of being left feeling disappointed in his attempts at relating to others.

His choice of language in the above extract also infers a possible child-parent dynamic present for him, perhaps since faced with someone of perceived authority. Specifically, '*doing bad things*' and '*play-up*' evoked an image of a child misbehaving, being naughty. I suspected Jawaad quite enjoyed testing his therapist but it also revealed both his sense of disconnect and his yearning to have his experience acknowledged. Incidentally in our interviews together I sometimes experienced a similar 'misbehaving' from Jawaad, most notably in how he described to me what I think he considered as some of the more titillating specifics of his story (for example, describing an orgy scene he had been involved in). I wondered if he was hoping to shock me, certainly retain my attention. Isolated and rejected, Jawaad had learned to entertain since reaction from the other provided at least some kind of validation.

Oliver's thoughts on therapist profile preferences were less explicit than with the other participants. Reflecting a general narrative of himself as 'patient' and professionals as 'experts', however, his hope and assumption was that the HSC assessor would know what is best for him in terms of who to assign as his therapist:

> *I do remember being asked male or female but my feeling was well I'll let you decide who you think is best for me. I have no real preference if it's male or female. You know 'I'm happy for you based on your assessment of me to decide who you think would be suitable for me'...erm I wasn't fussed but it was nice to know that if I was fussed...yeah . I mean it was said to me that they try to match you based on personality. Erm and I put my trust in that...erm it being the HCS, they wouldn't just let anyone rock up and do counselling you know? So I assumed that whoever I see will be professional and trained and erm personality-wise would get me, erm so I kind of put my confidence in that really.* (Oliver II33/6)

Oliver makes explicit his hope for a 'personality match' with his therapist. He makes equally clear his desire to be understood and accepted, for a sense of engagement and to be 'matched' with someone implies a harmonious coupling – one in which he will not be rejected. While hoping that one's therapist is suitably qualified may of course be an obvious expectation, there is also an implicit message here in Oliver's narrative that serves to reveal

an important aspect of his worldview and way of relating. Across the interviews and in the above extract, when Oliver spoke of his various interactions with his medical doctors and previous therapists, how he referred to them implied a very traditional relationship with such services – one characterised by deference. Such deference may also be an indicator of his self-doubt, however. He does not trust himself to make decisions, to take responsibility. Deference, therefore, in this context illustrates and maintains his sense of helplessness.

To summarise this subordinate theme, the key common message was that in order to embark upon their quest for acceptance, a fundamental prerequisite in the therapy was for a non-judgmental space to be offered and experienced from the earliest stages. As the participants began, underlying for all was a desire for a meaningful human interaction and connection in which they would feel truly heard, free from assumptions, stereotypes and judgement. They needed to feel assured that they could safely lay bare their vulnerabilities. As expressed in the previous theme (1.1) the core anxiety around judgment and fearing rejection had stemmed from a combination of life experiences and their associated own tendency to assume and categorise others. This in turn informed them that this is what their therapist could well do of them also.

It is also important to be mindful, of course, the setting in which these participants had their therapy – a charity agency offering free-at-the-point-of-use counselling. Therefore, in terms of how much they would feel able to state preferences may well have been significantly tempered by that awareness although this did not emerge in the transcripts. Nonetheless, what has been conveyed in this theme is essentially what they privately hoped for and what their anxieties and fears were about their therapist, and so in this context whether or not they made explicit their profile preferences is less relevant.

4.1.3 Subordinate theme: A need for therapeutic substance over style

As part of trying to capture a sense of the participants' perspectives as they began the process, I also wanted to understand to what extent the existential orientation of the therapy held any significance or relevance to them. In fact, only John had any prior awareness of ET and what it might mean in terms of the therapeutic work he was about to embark upon. In

all cases, however, there was little appetite for any exploration or explanation of the orientation. The essence of the encounter therefore, what actually happened and was experienced –the *substance* – was viewed as key to a successful therapeutic experience from the participants perspectives and of much more concern than the particular approach, or *style*, of the therapist.

None of the participants were advised of their therapist's orientation before their initial session so it was left to each therapist to determine how and if at all this would be attended to with their client. When his therapist introduced himself as an 'existential practitioner' at the start of the first session, John deduced that this approach would be attuned to addressing his presenting issues and needs:

> *Well I was aware that it (ET) is rooted in the humanistic approach and that for me is the core of what I'm about...I'm a very humanistic person anyway. So I am very aware of the language, it isn't something I would use (as a counsellor) but I'm aware of anxiety and death and sabotage and just this idea of every negative thing you have in your life ultimately being a fear of death, so I do get the real principle of existential therapy. But I wouldn't say I thought of my therapist in that way. My experience of my therapist was of being very humanistic, caring, supportive. I really felt that and I really needed that. I couldn't have had a therapist that picked at me, a more psychoanalytic, I just couldn't have coped with that type of therapy, I needed to be built back up as I had fallen apart.* (FU26-29)

Feeling that his life, his sense of being, had been shattered by the dual blow of his positive diagnosis and relationship loss, a therapeutic approach that was overtly analytical was too threatening a concept for him. Already in a state of crisis and emotional chaos, John needed a compassionate relational encounter that would acknowledge and affirm him at a time of intense fear and isolation. Above all, John did not want a therapeutic experience that was orientation-centred. In fact the implication is that an overtly theory-informed approach to the work would have distracted from the authentic human encounter he craved.

Jawaad also keenly wanted a relational and interactive encounter but in contrast to John's account, this was not how he initially experienced his counselling and indeed the preamble he received from his therapist about what existential therapy annoyed rather than informed:

> *I can't remember *pause* but I know something along the lines of saying 'I need interaction, I can't just talk at you all the time' erm and then there was I got a whole explanation about existential therapy versus something something, all this nonsense. I mean I can talk to you about proactive and reactive PR and you would just sit there and glaze over *laughs* you know? So there is no point in telling me what existential and whatever the various types of therapy there are, you are not speaking in a language I can understand... So you can explain until the cows come home, it is still not going to make any difference to me.* Jawaad (FU132-3)

By specifically asking for '*interaction*' from his therapist, Jawaad was also making explicit to her his anxiety about the therapeutic relationship. This had to be meaningful and he had to feel understood, he needed to experience engagement. Her response to his plea, however, was received as a retreat to professional jargon. While, as it later emerged in our conversation that the therapist subsequently spent considerable time after this unpacking his request, Jawaad experienced this initial response as effectively a distancing from him. It would seem that by firstly focusing upon the theoretical underpinnings of her orientation she positioned herself as the professional in the room. Only within this context did she subsequently explore with him why he wanted interaction. By framing the therapeutic space first theoretically, rather than relating to the human emotion there and then, something was lost from this early exchange. If we remind ourselves of the worldview that Jawaad held as he began, feeling persecuted for being who he was, dismissed and rejected in his workplace, one can assume that it would have taken considerable courage for him to voice this plea for interaction. Meeting this with a detailed description of therapeutic modalities seemed to contribute significantly to at least a slowing of rapport development.

Like Jawaad, Oliver was not minded to enter into dialogue with his therapist about orientation but in his case this was because he envisaged the potential for avoidance and sabotage of the sessions that this might provoke in him. He had knowledge of CBT as the therapy of choice in the NHS and as such considered that it must therefore be amongst the most efficacious of approaches. In terms of ET, he had no prior awareness and reported feeling '*suspicious and curious*' (II188) about it as he began. In the following extract he reveals his ambivalence towards exploring what ET might be like in practice:

> *She did mention something about existential...I asked 'well what is existential?' and she did explain it a bit erm but I wasn't sure…I wasn't really sure if I got it and I wasn't sure if I should just say, ask her more about how existential therapy works because I thought if I start thinking about well what is it she's trying to do is that just, without me even realising it, is that some kind of resistance to the work?* Oliver (II48)

So a danger resided for Oliver in any extensive attention upon the process and orientation. If he endeavoured to become well-informed in the approach then there might ensue an ongoing appraising of what the practitioner was 'doing'. A mental joust, perhaps, instead of immersing oneself in the actual process itself. As with all participants, Oliver conveyed a need to feel safe and supported in order to to fully engage in the therapy and so maximise the possibility and potential. While he was fearful of what he had to face and what may emerge, he was equally clear that he had to find the courage to confront his pain. This mattered to Oliver and the significant emotional investment involved in committing to this counselling from the outset is evident.

Unlike for the other participants, there was no such discussion around orientation for Michael. He did not know in fact until he read my research information sheet that his counselling had been with an existential practitioner. There was instead just a basic framing of the space for him, as he recalled:

> *Erm *pause* it was that she just wanted it to be a kind of safe space, like somewhere to free-flow type thing but she didn't go into too much technicality around what she would be doing. And that was fine, that pretty much was what I was after so...yeah* (II9-10)

Perhaps his therapist recognised Michael's sense of urgency from the outset although this is not definitive. It is nonetheless notable and informative that from the perspective of this particular participant that when in his state of emotional despair, the most basic framing of what was being offered was appropriate.

To summarise this subordinate theme, all participants were clear that of paramount importance for them was that they could readily feel able to immerse themselves in a process of understanding and discovery. Equally clear was that this would best be facilitated by feeling

safe enough to identify and confront their pain. There were specific concerns raised by some participants including a fear of an approach that would feel overly analytical, or indeed an over-emphasis or extensive time spent by the therapist in seeking to explain as Michael said, the '*technicalities*'. To invoke the journey analogy, what mattered most for all of the participants as they embarked on their counselling contracts, was reaching their desired destination, and feeling safe and supported as they travelled.

4.2 Major theme 2: A time-limited existential exploration

Having attended to the each of the participants' perspectives as they began their therapeutic process, this second theme addresses how the actual counselling was experienced by the participants. Essentially, I wanted to capture what might be considered illustrative of the existential time-limited approach in action by conveying how the sessions and the twelve-week contracts as a whole were perceived. Specifically, this is about the participants' reflections upon what felt of particular relevance and importance for them in terms of process, and how the relational aspect of the therapy contributed to the work. Again, at the core of this study is the aim of understanding these participants' experience of a time-limited contract and as such their recollections and thoughts upon this key aspect are analysed.

4.2.1 Subordinate-theme: A meaning-revealing journey

Central to this research has been seeking to understand what form the counselling took, how it was experienced and specifically what was recounted as notable or significant for the participants in terms of *how* the content emerged in sessions. I wanted to capture any commonalities between participants emerging in terms of the form the sessions took. Essentially the aim has been to gain some insight to what existential time limited counselling looks like in practice and how it is experienced.

For all participants, an inquiring of attitudes, assumptions and the questioning of their way of being, emerged as being central to the dialogue and process. The exploration was first and foremost an exercise in meaning-making and understanding of both the current worldview

and how this influences their situation. Within this framework emerged the opportunity to contemplate alternative ways of being, and indeed as evidenced in the extracts below, some profound realisations were reached.

Oliver described the power of confronting his fears and how he did this by articulating and verbalising what they were. In this act of sharing with another, a sense of relief was experienced:

> *I think (counsellor) always *pause* always asking the question 'well what do you think will happen if you do something you are frightened of doing?' or 'what will happen if you don't do something you are frightened of doing?'. Making me articulate things and to focus on these different scenarios and and and erm cos I think everyone knows, you know the answers to those questions but it's one thing to know it and another to say it, and get it out! Erm and really *pause* examine it, you know, looking right at it*. (II104)

By the therapist inviting his client to examine what his life might be like depending upon the future choices he makes, Oliver achieved clarification around his fears and the perceived obstacles to realising his hopes and aspirations. While the interventions were not experienced as particularly revelatory in themselves, by attending to his narrative, their function was to invite a confronting of his fears and choices made and contemplating alternative choices that he could make going forward. There is an element here of the therapist as simply, but effectively, a witness to his reflections – he is not looking to her for answers. Such an engagement from Oliver nonetheless required much courage, particularly if we consider in the context of how he was concerned about his tendency to avoid the pertinent material.

Jawaad similarly described a sustained questioning aimed at uncovering the obstacles to a fuller and more meaningful engagement with living. He offered an especially revealing example of how his therapist challenged his attitudes and the meaning that he attributed to key aspects of his life:

> *We talked about, the source, or some of the reasons behind some of the feelings of insecurity. Erm, I talked about my particular spin, just telling my life story. Erm we talked about my love life, my attitudes towards love, which is interesting because I actually learned something. She asked me 'when you think of love, what does it*

> *mean?', and I said 'unhappiness'. And that was just during a session and I remember telling her that it was very useful...And then she…she wanted to find out, she drew a nice diagram*, and she said 'this is (*pointing to one end of 'line'*) me now', and 'me happy' (*pointing to opposing end*) – and having these factors that would take me to happiness and meeting this man who had all these factors, ticking all these boxes, and then hitting this barrier and pulling myself away. 'What was the barrier?' (she asked)...and I realised that I am afraid of letting myself go because loving or being loved equates to being hurt.* (II98-101)

This proved to be a fundamental realisation and recognition of the underlying anxiety that he carried about engaging in meaningful relationships. The vulnerability inherent in revealing ourselves to another was too high a risk for Jawaad. Experience had informed him he was essentially unacceptable and so would ultimately be rejected. His counsellor challenged his 'excuse' for avoiding intimacy and sought to understand his worldview by inviting him to describe and define his narrative. I think particularly notable was his term of '*particular spin*' – as a public relations professional this was terminology he would presumably be familiar with. The implication is of an acknowledgement of a constructed and at least partially (and knowingly false) narrative. Considering this extract within the context of his presenting issues, fearing both emotional intimacy and rejection provided credible explanations for Jawaad as to why he had adopted the coping strategies that he had (the combination of drugs and compulsive anonymous sex). That is, these were an attempt to distract from or avoid the inevitable pain of being with another (as well as a maladaptive strategy for validation as he alluded to elsewhere).

Like Oliver, he described his sessions as a process of uncovering of obstacles to more meaningful and authentic living. In Jawaad's case the notion of obstacles, or barriers, was made explicit by his therapist. The drawing proved to be a powerful tool in crystallising his dilemma. More than this, it conveyed to him that his therapist understood him, was working with and for him. She was visually displaying how her role was to facilitate his uncovering and making sense of his attitudes and fears. Jawaad experienced a much-valued, indeed much-needed, realisation here. Together they were reaching the essence of his worldview, which was that to love was to be hurt since he will inevitably be rejected. There was a causal relationship between them and his entire way of being-in-the-world was informed and guided

by this conclusion. Incidentally, this was particularly striking for me to hear Jawaad's experience of the session content in light of the considerable reservations he held about his therapist in the beginning, and indeed which endured as will become further apparent in subsequent subordinate themes.

John experience was that his therapist's style of questioning facilitated this being a largely manageable and accessible process of confronting head-on his pain. While Jawaad described a restructuring of his dialogue, John described his conversations as essentially intended at deconstructing or unpacking for him of what initially felt like a confused and impenetrable mass of distress:

> *It was about unwinding things so that it wasn't this one big ball that I couldn't deal with. I had to have it broken down, little by little - just pull it out and make it more bearable for me, so that I can look at it.* (II33)

He is echoing Oliver here in his assertion of the power of candour. The honesty in revealing was in itself therapeutic. The enormity and confusion of his myriad of thoughts and emotions were overwhelming and this was as much about fearing the unknown. To invert a metaphor, John needed to see the trees so he could comprehend the woods. The task may have been daunting but throughout he conveyed a deep desire to confront, contemplate and comprehend - and it was an opportunity to do this that his therapy afforded him.

In the following later extract, he explained how this process of describing and meaning-making engendered an early and welcome shift in his mood and attitude:

> *I went from a place of such isolation and loneliness and just ...terror in a way... I felt I was just breaking down and I just needed somewhere to go with that. And just to have that space and do that, describing how I felt, making sense of it, I quite quickly kind of started getting more happy again...and positive again, and felt much healthier and you know OK about myself and that probably happened in the first four to five weeks.* (II67)

By relating to the Other in this unique space, and done so via an honest dialogue about his emotional responses and cognitive processes around what had happened to him, facilitated a substantial and dramatic shift for John towards a more accepting view of self. We can readily

see here how John travelled – at pace – from a place of utter fear and isolation to at least the beginnings of a much more integrated sense of self and wellbeing. So there was an empowering effect achieved by the process of describing, clarifying, and understanding - and being heard by another.

Indeed from our interviews, and John's accounts, I was left with a lasting sense of both the intensity of his felt isolation, terror and confusion at the start of his therapy and then crucially the substantial movement towards an embodied sense of relief and calm as he progressed towards the end. It appeared that by making sense of his predicament, by finding meaning, John reached a place of emotional wellbeing.

Turning to Michael, I could again observe an example of a sustained questioning and challenging of the current worldview. Michael spoke of the major themes to emerge in his counselling to be around his low sense of self-esteem and lack of assertiveness. He explained how this had often manifested in his acquiescence to others for fear of rejection by them. When I asked him to reflect upon *how* this emerged in his sessions, he explained that together he and therapist explored his current view of self and how he interacted with the people in his life. By engaging with this, a dialogue of contemplating alternatives was then facilitated:

> *...trying to find a way of dealing with the self-loathing of my personality and we went quite deep into that I think. We did. Erm friendships and understanding and maintaining boundaries around friendships and exploring, how I just felt swamped. And I hated it. Really fraught. Erm in the beginning it was around exploring the breakdown of a relationship and how that had impacted on me in quite a big way. And then onto how I move forward or perceive of going into future relationships from there.* (FU40)

This was about understanding how his attitudes and view of self directly impacted upon his ability to relate. Notice how he described the self-loathing as being '*of my personality'*, suggesting he considered it to be an innate part of him - it was *of* him. A defining relationship to self seemed therefore to be one of hatred. Attending to that in the counselling can be assumed to have been of fundamental importance and again a head-on confronting of the

underlying narrative. By making sense of how things are and have been in terms of his relationships with others, a dialogue around how things could be emerged for Michael.

By Michael exploring his lack of functional boundaries highlighted for me, as so with Jawaad, a struggle with intimacy. On beginning therapy, Michael had no or little boundaries with his (mainly female) friends, something which led to him feeling vulnerable and exposed. This was confounded by an enmeshment with their wants and needs - he was '*swamped*'. Consequently, he could not then truly understand his own needs, and how they could be attended to. His therapy offered a place to uncover meaning and so reveal possibilities for alternative ways of being in the world.

For all participants, therefore, this was fundamentally a journey of uncovering and learning. The primary focus of the therapy was about describing, clarifying and making sense. Through this, a connecting with the associated felt emotions and feelings was instigated. For all, the existential therapy was largely experienced as insightful, informative and crucially concordant with their objectives from the outset. The type of questioning from their therapists indicated a descriptive, investigative exploration in which attributing meaning emerged as the principle objective and so provided the fundamental shape of the work.

4.2.2 Subordinate-theme: How a relational alliance is the conduit for change

The salience of the relationship between participant and therapist permeated all transcripts and as such is essentially present in all the themes presented in this report. Therefore it is my view that an attempt to capture this definitive aspect of the therapy in one subordinate theme would not adequately reflect what emerged from these transcripts and how fundamental and omnipresent a factor it was. Equally, to pronounce that one finding from this research is that the therapeutic alliance is important to process seems in itself to be not particularly revelatory. What I hope instead to convey here is *how* by the participants and their therapists being together, in their unique and co-constructed relationships, shaped and influenced what occurred.

An impression and experiencing of genuine engagement and dialogue with the therapist emerged as prerequisites to the establishment of an effective and early working relationship for all. This in turn was identified as a precursor to meaningful work since at the heart of this was the development of a sense of safety, acceptance and attention. As already made clear by the participants' accounts, this was essential not only in facilitating the therapeutic process but also as central to their counselling objectives. Where this was not experienced, the pace and content of the work was reported as being substantially hampered. Crucially, it was the conveying of a normalizing and affirming approach by the therapist that facilitated an exploratory dialogue with the participants and their narrative. This emerged as the most significantly effective factor in engendering a sense of self-acceptance, and so a conduit for a new relationship with self and world.

As highlighted in the first major theme, Michael began counselling with a considerable degree of anxiety and fear about the process and about his counsellor, largely generated from a debilitating low self-esteem and profound fear of rejection. Therefore, the early development of a strong relationship between himself and his therapist would be vital. He needed to feel safe before this could fully engage in the process:

> *Something has happened definitely. Because in the first 2 sessions I remember being in that desperate state and almost scared of (counsellor) in a way, not knowing, and almost apologising for me being there. But as the weeks progressed I became more and more animated and it was...it was a confidence building thing and maybe that was the relationship that was helping with that.* (II199)

A rising self-confidence as the weeks progressed Michael considered to be possibly correlated with the therapeutic relationship and an experience of feeling accepted, his source of validation. Although he is tentative in the above extract, there is nonetheless a sense of him feeling increasingly safe and enabled to be authentically Michael, to be able to articulate his thoughts and not fear dismissal or rejection. The therapeutic relationship facilitated an arena for acquiring confidence and a place to test a new way of relating.

Earlier in the same interview, Michael described his experience of his therapist as someone who was both conveying and demonstrating an understanding and sense of commonality

with him. This was foremost in his recollections when I asked him what in particular had worked well in the therapy:

> *I would say, I would say her...stands out first and foremost... Her personality, her manner, her warmth, her presence, she's very friendly, friendly person so out of everything it was (counsellor) herself. She was quite down to earth and her ability to relate to what I was saying and what I was feeling and what I was going through, and sometimes she drew on personal experience as well. Not all the time but I think where she saw it as appropriate, she would draw on her experiences. (for example) My motivation, and erm wanting to join the gym, but *laughing* not actually going through with it *laughing*…How she, you know, has gone online and almost bought the sort of buttock-cruncher machine you know what I mean, and she said it's just gathering dust as a clothes horse or under the bed *laughs* And about the relationships as well...just you know past relationships or experiences she's had (for example) 'well this sort of happened to me...' erm *pause* Yeah not that the situation is the same but similar...(which was) Good. It built the trust*…It made it easier, very much so. More human. (II128-142)

As well as communicating empathy and understanding, the personal disclosures from the therapist also appeared to cultivate a message of solidarity ('*we are alike'*), while at the same time not discounting the challenge or uniqueness of his situation. Such disclosures from the therapist were experienced by Michael as being to an appropriate degree rather than being a distraction or losing sight of his story. The therapist self-disclosing was received as a facilitator for their interaction and particularly in his meaning-making process. Notable also is how the humour in the room was experienced positively and appropriately, there was no sense from Michael of any trivialising of his predicament, which again added to the overall impression of a strong working alliance. The message being communicated seemed to be that '*we are similar as well as different. I can understand your pain. I too have vulnerabilities, insecurities, shortcomings, imperfections – indeed perhaps this is the human condition*'. Michael certainly deduced from this that he could risk laying bare his vulnerabilities to this therapist and in so doing increased the opportunity and potential from the process.

John similarly relayed a view that the message implicit in the therapist's general discourse offered him the potential of achieving his goal from the counselling:

> *Yes, and in a way I suppose accepting in that it's not my fault, it's not, I didn't do anything evil, I didn't do anything wrong, it's just a virus like any other virus and not*

> *that he (therapist) said that specifically but it was implicit in the accepting dialogue, in you know that I wasn't this diseased horrible person, that actually I was ok and I can accept HIV and I think I was talking about me wanting to be more comfortable with it and have it that it is not a stigma in my mind.* (II126)

His language here betrays the guilt that he was carrying, and which he assumed that others attributed to him also. Crucially though, the affirming discourse of the therapist had both a reassuring and assuaging effect for John and so fostered a self-affirming narrative. John also seemed to assimilate what lay at the core of his issue with the HIV diagnosis. Fear of loathing and rejection from others became more focused upon a realisation that this in fact was about him and his views – a projection of his internal conflict and struggle.

At John's follow-up interview, he described what he considered to be the foundations of the strong relationship he had formed with his therapist:

> *I think it was about feeling held by the therapist and being able to trust that they could handle what I was bringing to them, and feeling that I wasn't being judged, they were seeing me as a person, a human, not a therapist who should have known better.* (FU24)

Probably the most instructive comment here from John is that his therapist met him as a '*person, a human*' – giving us a real sense and confirmation of both his fears on entering the therapy and the value and benefit that he attributed to this relationship since. He experienced an accepting, trusting space in which he could expose his vulnerable self – a human with inevitable frailties and ambiguities. From this experience, he described an increasing ability to trust others in his life, to ask for support when needed, something which could be directly attributed to the therapeutic relationship. Specifically he observed that this was so '*by experiencing a counselling relationship that I could trust the person, they could take it and still be there'* (John, FU75).

The therapeutic relationship served as a modelling experience for John. Here he had been in the company of someone who was solid enough to bear hearing his pain without fleeing or abandoning him. This helped develop and inform his emerging ability to trust others in his life. One caveat here on these reflections I think is that it is important to remember that John worked as a counsellor himself and this latter comment about what the relationship provided

him, does feel rather 'text-book' but when considered within the context of the extensive reflections across the two interviews it seems reasonable to interpret this as a genuine reflection of his experience of the therapeutic relationship.

For Oliver, someone who was immersed in a sense of isolation and aloneness, the simple fact of physically being with another was identified as of particular significance, almost regardless of session content:

> *I think our personalities were very well matched and and some weeks we'd have more to talk about than others. Erm either way whether it was a week I had a lot to talk about or not a lot to talk about, it was nice just to sit with someone you can relate to and get on with. Erm if it's just a shared joke but either way it just felt quite therapeutic.* (II108)

So there was a healing element from this co-created togetherness which the participant attributes to his general sense of commonality between them. He describes the sessions as a conversation as between friends which was typical of how he spoke of his therapist. Above all else for Oliver, this was about being with someone whom he felt heard him and who showed herself to be able to be with him and acknowledge his emotions.

In our first conversation about this research, Oliver told me that the primary reason he wanted to participate was because he thought so highly of his therapist, implying that he somehow owed her (and HCS as a free service) this '*feedback*'. However, Oliver's participation could well have been in part explained by a frustration that the counselling actually did not address what he wanted it to. As described earlier in 1.3, since Oliver approached from a position of deferment to the professional, he explained that the issues he actually wanted to confront were not since the '*experts*' did not appear to agree with his own analysis:

> *I call it an addiction and it's quite interesting, when I did the assessment *laughs* I kind of got the impression that well it's not really an addiction you've got, and (counsellor) kind of said the same thing when I spoke to her about it so I thought 'oh well they don't think I have an addiction'... Well it was good in a way to hear that I don't have an addiction compared to other people they encounter...so maybe it's good that my problem is not as severe as perhaps I thought it is. *pause* I do think I have a problem and I think I do want to deal with it and so maybe I'm not getting to the bottom of what it really is...I do kind of think there was something there that perhaps*

> *I would wanted to have focused on and directed the counselling around but then I wanted to just go into it and see how it works and let the professional do it how they wanted to do it*. (II42/3)

While the initial explicit message from Oliver in the above extract is a degree of relief or reassurance, there is I think an implicit and considerable sense of frustration and dissatisfaction that his key objectives being had been left unfulfilled, an unsatisfying outcome which he attributes to his therapist. It is striking then that within this context of his reality being effectively questioned, even dismissed, that he described the therapeutic relationship generally across his transcripts in such distinctly positive terms. The apparent lack of anger or resentment at his therapist may instead have been implicitly present and felt but concealed. So possibly one motivation for participating in my research was Oliver taking an opportunity to finally give voice to this disapproval, albeit tentatively and relaying it passively. Possibly. He evidently acquiesced and so colluded with his therapist in her rejection of his formulation, which would be reflective of his self-declared tendency to avoid the salient issues. His hope for a return to his primary concern around addiction would only have occurred had the therapist decided to go there, not by his own volition – it seems Oliver was being 'allowed' to avoid the difficult areas. Here then is a possible collusion between therapist and client acting as an obstacle to the client's desired change.

Perhaps the most seemingly contradictory reflections of all in terms of the therapeutic relationship were from Jawaad. In the previous theme (2.1) he described substantial depth of exploration and a valued process of making sense of his life. However when I asked Jawaad to reflect upon how he experienced the relationship with his therapist, he instead described a lack of any depth or connection which in turn resulted in the quality and content of the work being fundamentally compromised.

From a relational perspective, he told me of two distinct phases to his experience of the therapist. In the first (approximately) six sessions of the contract she was predominantly silent, offering minimal interventions or reflections which proved discomforting for Jawaad

and served only to exacerbate his fear of judgement. Silences could be long and provocative as he explains in the following extract:

> *Sometimes the silences would follow 'so tell me more about this', and I would say 'I'm not sure what I want to say' and that is how it would go. Because there was an uncertainty around how much I could say, how much I was comfortable with saying, cos 'I don't know you!' I can't speak for anyone else but I know for me it was a case of 'you'll be judging me because I am judging me'... Whether you are or not is irrelevant. It is what is going on inside me. 'I am judging me so therefore you are judging me'. *pause* That's my perception.* (FU61/2)

His uncertainty around what was appropriate or acceptable for him to disclose to his therapist suggests that his intense anxieties around being judged, persecuted and rejected were being triggered. The silences were being experienced as punitive, and not as a space for reflection or contemplation which was presumably the therapist's intention. Instead the space held risk and was not yet somewhere Jawaad could feel free to explore his vulnerabilities. Perhaps, given his acute feelings of being a victim of discrimination, there was a degree of inevitability to this lack of an early therapeutic alliance for Jawaad. Maybe in fact what is actually being revealed here is the depth of his pain and fears and therefore this was the work taking place, his therapeutic journey in-action.

Observe how the participant is talking directly to the therapist in the above extract, a method often employed by Jawaad in our interviews which typically suggested to me an ongoing and present dialogue that he was having with himself about the therapy. In particular, the anger and frustration he was holding around his sense of a lost opportunity is being revealed. However, while Jawaad is expressing this frustration of time having been wasted, there also emerges an important insight in that he is readily acknowledging ownership of this judgement: recognition of his projection of persecution of self.

Nonetheless as well as this acknowledgment of his own role in the lack of a therapeutic alliance, there was also a definitive view on his therapist's responsibility for this. Jawaad described an unmistakeable emotional disconnect between them which he depicted as a '*screen between us, it wasn't a line it was a screen between us. (*FU156). This was more than the perhaps expected delineation then between practitioner and client. There was something

more absolute here – something impenetrable, protective and defensive – that rendered his attempts at relating as essentially futile.

In this follow-up interview we had spent considerable time around the relationship and what had occurred between them given the depth of frustration that Jawaad had so readily expressed from the outset of our first meeting. I asked Jawaad if he could think of any specific example in terms of his experience of a very restrained therapeutic relationship, which he readily provided:

> *I remember asking her something...I don't think it was that personal I can't remember what it was...I think I asked her 'what do you think?' and she said 'I keep the two very separate - what I think personally and what I am here to do' and that just alienated me even more... Yes...'that's private' (she said)... Yes because for f**k sake...'oh sorry but I am here exposing myself to you and you can't even give me an opinion?! Why should I engage with you then?'* (FU100-3)

This depiction of a dichotomy between the professional and personal undoubtedly had an extremely inhibiting affect upon what Jawaad felt able to disclose. What may well have been an intention by her to return and maintain the focus of their exploration to Jawaad and his views was instead experienced as a rebuke and caused significant damage to their relationship. From a place of isolation and fearing rejection but hoping for and needing a sense of relating to another, Jawaad would have had to source considerable courage to engage in therapy. His therapist's response here served only to intensify his sense of isolation and confirmed to him that if he tries to relate, he will be rejected.

To reiterate Jawaad's context of feeling judged and persecuted by people in positions of authority in his life, his reaching-out to his therapist from the early stages was indicative of an awareness that he needed to feel affirmation and acceptance from her. Jawaad was craving emotional intimacy, an emotional availability with someone with whom he could be authentic and explore his painful feelings, emotions, and the associated behaviours that were significantly impacting both his emotional and physical wellbeing. In his state of self-loathing, he sought explicit validation of his right to be. That he did not experience this confirmed to him that once again he was being judged for revealing who he is and for that he retained

much anger, hurt and feelings of rejection in the interviews. This particular experience potently illustrates how the degree to which the therapist engages with the client, how much they bring themselves into the room and the subsequent co-created dynamic are pivotal to what subsequently emerges.

However, in the latter half of the twelve week contract, Jawaad experienced his therapist as much more interactive and relational. In sharp contrast to the earlier sessions, her interventions and manner informed him that she was being attentive and attuned to his needs. Finally he was getting what he had sought, as he explains:

> *In the second half, the last six weeks or so, when I started getting a reaction* (FU50)
>
> So that was the point when you felt 'there is trust now...I can open-up more'*?* Int.
>
> *Was it trust? Erm...I think it was engagement in fact, you know? I felt I could finally trust that she was *pause and emphasis* engaged!* (FU51)

Therefore this was first and foremost about being assured that the therapist was fully present and attending to his narrative. Jawaad needed to know that his narrative was being treated with due gravity and therefore that he was being afforded due respect. Informative also in this extract is how the participant heard my question. Perhaps Jawaad thought I was implying relational warmth had developed between them. I suspect the depth of his anger towards his therapist that he continued to hold would have barred such a concession of trust. Mindful of Jawaad's wider context, for him to reach a place of trusting the other would rarely come with ease and particularly so in professional settings. Incidentally, on reading again this brief extract of an exchange of ideas between the participant and myself exemplified for me the meaning-making process at the core of IPA research and the collaborative and clarifying dialogue that this requires.

To summarise the underlying commonality between participants in this subordinate theme; the extent to which the therapist is experienced as being engaged and involved was a major contributing factor to therapeutic outcome. Indeed an experience of co-creation and collaboration in the enterprise is more than fundamental to the process - it *is* the process.

Where a sense of sameness and togetherness was conveyed from the therapist, by way of self-disclosure for example, appeared to communicate inclusion, acknowledgement and was received as affirming. This in turn facilitated for the participants the opportunity to contemplate a new, more respecting and accepting relationship with self. Conversely where professional boundaries were asserted, a message of remoteness, detachment and difference was conveyed which risked exacerbating or consolidating the essence of the presenting issues - self-loathing, isolation and fearing rejection.

4.2.3 Subordinate-theme: The opportunity of the time-limited setting

A further key aspect of the research rationale was seeking to understand how the existential therapy was experienced specifically within this time-limited twelve week frame. Reflections from all participants suggested a clear awareness of the limitation from the outset and while this was at times anxiety-inducing, it also seemed to serve as a catalyst for a more intense and vital focus to the sessions. That is, a potential for significant therapeutic benefit was afforded precisely because of the time-limitation. By actually engaging with the time constraint and in particular the inevitability of the ending provided participants an opportunity for experiencing a new way of being with others, including communicating one's needs.

For all participants both the contract duration and the impending end were made explicit by the therapist periodically across the twelve sessions. This instigated notable degrees of anxiety as the weeks progressed and the ending neared, although perhaps most so for Michael. He had made plain in his interviews a general unease with 'wasting time', at one point reflecting '*I could go any second... what I have been through I think that yeah, time is precious'* (II165). This acute awareness of the fragility of life was matched by an intense appreciation of it being finite. Michael had faced mortality at a number of junctures – the death of his father, closely followed by his HIV diagnosis and then a subsequent battle with an aggressive cancer. It seemed a striking paradox, however, that in declaring this preciousness of time, he was a man who also described to me lost weekends unable to leave his bedroom, paralysed by depression and engulfed by self-loathing. This conflict between his

way of being and his worldview was a key aspect of Michael's un-ease in life. In terms of how this awareness manifested in his therapy, he described counting-down the number of sessions he had left each week, dreading the approaching ending:

> *'oh this one oh no that's another one gone, so that's just nine left, oh now just seven left'...and really not wanting it to end but ultimately it has to erm but yeah there is the whole timescale was a major factor for me.* (II191-2)

While there appears an acceptance of the limited contract, Michael is plagued by a fear and deep dread of endings in life and this loomed large in the therapy. It was within this emerging picture and context that I sought to explore further with Michael if there was also a possibility that this very anxiety could have also engendered some sense of urgency to his therapy:

> *Did it come in the room? Did *counsellor* name how many sessions you had left? (Int)*
>
> *Yes oh yes she said that. At the end of each session she would say 'you've got x amount left now' (II193)*
>
> *OK and would you say then being aware of that, affected the work in any way? (Int)*
>
> *Erm...*pause* not really I don't think. No. (II194)*
>
> *OK but I am wondering again about what you said earlier about hating wasting time. I am wondering if that came in at all? (Int)*
>
> *Yes possibly. Hmm. *pause* Yeah! Actually! [raises voice]...cos in my head although I had all these expectations maybe in my head I was reflecting that? Wanting to get as much out of this as possible. So kind of use it wisely. Try to get as much out of...I was very vocal throughout.* (II195)

I have included my interventions in the above extract for the purpose of transparency in showing how I explored with Michael the temporal anxiety which he has depicted permeating much of his life. He described himself as someone who typically is eager to be liked by the other, indeed desperate to be accepted and so affirmed. I am therefore mindful of this when Michael so readily concurred with my line of enquiry in the above extract. I am also conscious how my own preconceptions could have been leaking into my questions at this point and my own way of being with Michael. This said, I do think Michael's transcripts portray an animated

interaction by him in most of his sessions, being very engaged in the process which lends support to the sense of urgency and vigour that he postulates on above. Such an engagement would indeed seem congruent with someone acutely aware of the fragility of their existence. So there is a sense of particular relevance, even appropriateness, here for Michael's counselling being explicitly time-limited.

Echoing this idea of urgency fuelling the process, in the extract below John also explained how he experienced the depth of exploration to be significant and not compromised by the twelve week constraint:

> *(It) did feel like a substantial bit of work, and I suppose in a way it did make me focus more...and after twelve weeks it would have gone deeper but we went quite deep anyway, it wasn't on the surface. I've faced some painful and difficult things in the twelve weeks.* (II138)

John entered therapy clear about the issues that he wanted to attend to. His awareness of the timeframe facilitated an enhanced energy to his sessions and, crucially, he had confronted his pain to an adequate extent within the timescale. In fact maybe the intensity of his despair meant that this was as much as John could have tolerated at that particular moment in his life.

Where a difficulty did emerge for John in terms of the time-limited frame was in his perception that he had no control or choice around the timing of the ending. Although in fact he did have some since service users are entitled to a *maximum* of twelve sessions but can of course terminate before this should they choose. However, for him reflecting the worth he attributed to the therapy, when to end was not a collaborative decision and as such a valued relationship was being taken away from him:

> *It's one that I struggle with. You know I knew it was time-limited but then again I think towards the end it kind of reinforced for me that this wasn't my choice for this to end you know? So there was that sort of element to it. And having to deal with that you know - understanding that that is how it is but also dealing with a sense of loss. You know this is a relationship in the way that is ending in a way that I didn't want it to end and I quite enjoyed and looked forward to and now I won't have. So you know to have*

> *the sense of loss of that, that space. Yeah it's sad...I feel sad. But it's tolerable cos you know I can contain that and know that but it's kinda like I'd made a friend and they have moved on but I'm happy I had that time while I had it. That's what it feels like.* (II55-7)

There emerged for me here a real sense of a transformative journey for John and one that was in important ways specific to a time-defined setting. He began therapy engulfed by the pain of his relationship loss, terrified about what his diagnosis meant for him, feeling isolated and ultimately fearing judgment and rejection. In his sessions he experienced a relationship and space that was meaningful and that he clearly cherished. It offered him something, perhaps a sense of hope, acceptance, and optimism. The therapeutic relationship developed with him fully aware of the time constraint. As a counsellor himself he understood well why this was so but nonetheless something that mattered was being taken from him. John was already overwhelmed by loss as he began his therapy and so as well as the imposed ending inducing further sadness and loss in its own right, it also triggered his underlying intense fear of being abandoned and returned to despair and isolation.

However, in the above extract John also describes recognising that while losing the therapy and the relationship ending was painful and regrettable, he could also acknowledge and appreciate the value of what he had while he had it. There is an acceptance of an uncomfortable yet bearable tension or paradox in which the more valued a relationship is and the more one invests of oneself in it, the more pain there may be endured when it ceases to be. This does not mean it is a futile endeavour or to be avoided, but instead that it should be enjoyed, valued and indeed mourned when it has gone. This seemed to be a hugely significant insight for John and suggests a philosophical engagement by the participant with how he is in the world and in relationships, again facilitated by an explicitly time-limited setting.

In sharp contrast to John's experience of both a corresponding sense of depth reached and an evidently strong therapeutic alliance being forged within the time-limited frame, Jawaad recounted a deep frustration which he principally attributed to the lack of an early therapeutic working alliance, as described in the previous theme. In the following extract he explains his

sense of futility about the process from the perspective of being mindful of the time constraint:

> *Erm sometimes I just kept thinking is this worth it in this timeframe that we have got? By the time I have got my story across and we have explored, time will have run out, and that's kind of how it went. By the time I made a connection with this person, and identified the areas we should look at, it was time to end.* (II208)

Jawaad could not tell his story until he felt a connection with his therapist. Equally, his anxiety around there not being enough time given such obstacles is evident. Since the relationship was slow to develop, his narrative was slow to emerge and so any hope for a sustained and meaningful exploration was substantially compromised. The participant is quite clear on the causal relationship between establishing a therapeutic relationship and engaging in addressing his issues – the latter cannot occur without the former. As was often so with Jawaad when talking specifically about the therapeutic relationship, there was a palpable resentment in his narrative, which as I think so here, typically manifested in a definitive dismissal of the experience as futile. There is little room for nuance or ambivalence here, although as will emerge in subsequent themes, this was not always the case.

I returned to the notion of futility and wasting time, or not enough time, in our follow-up interview to try better understand what he was telling me:

> *Which brings me perfectly to the next quote from last time...you spoke about the first six weeks where the therapist said nothing, which was not useful for you, erm...and you said the result of that was 'skirting round the issues and losing half the time' ...so does that mean you were left feeling that time had been wasted?...* Int.
>
> *By the end of it yes.* (FU54)
>
> *So you lost some*...Int.
>
> *interrupts* *valuable time.* *pause* *I may be wrong but I would suggest that in some scenarios the counsellor does take the lead. Again, it is based on individual basis, you can't make a sweeping statement but if you are going to make a sweeping thing of twelve weeks then you have to follow that up with some other things where you do encourage the counsellor to be more proactive in the relationship with people they are counselling in terms of helping them to open-up much sooner. It's not the ideal*

> *scenario but then neither is twelve weeks. So if it is only going to be twelve weeks then you might as well make it that that person can get as much out of it as they can. So yeah it's not an ideal situation and it's not what you would want to recommend to all your counsellors but there needs to be an element of engaging from the start and if you see a person struggling, give them something* (FU55/6)

Time was of the essence and this opportunity of therapy mattered to Jawaad. He acknowledged that his sense of persecution and isolation could well be distorting his assumptions of the therapist. However, crucially here, Jawaad reflects that since this may well be the case, there should have been - and needs to be - an overtly relational and explicitly affirmative presence by the therapist from the outset in such a time-limited contract. Without these combined therapist attributes, the pace of the work was too slow and he was left with a residual sense that an important opportunity had been lost. This is about making the most of what you are given, Jawaad is telling us. The restricted number of sessions by definition imposes constraints and limitations on what can happen. The therapist needed to be cognisant of that and adapt her approach accordingly.

Oliver meanwhile had rather more favourable initial recollections of his experience of the time-limited setting, which he considered was likely reflective of him ending the contract in a positive mindset:

> *If it just happens to be my mood, at this point I can't say. So whether it is by chance or by design, I don't know. At the moment it seems that it was the right amount of time, and I think if you want to kind of explore a problem and look at it and examine it – to me, that feels like the right amount of time to look at it, to open something up, look at it, and deal with it. I don't know why, instinctively, twelve weeks just seems to be the sensible amount of time.* (II155)

There is an implicit fundamental pessimism in Oliver's cautious optimism here – he is saying that he feels good presently but also infers that this is in some way colouring his judgement. Listening to Oliver, my sense was that he expected this somewhat positive appraisal to be transitory and unlikely to endure. His familiar experience was to eventually revert to a bleak assessment of his lived experiences. Nonetheless we cannot discount his intuition here that the twelve-week format felt both sufficient and appropriate. Transitory does not mean

inauthentic. Notable also, and perhaps evoking his general deference to the professionals, we can observe a nod of respect for the service when he declares the timeframe to be '*sensible*'.

It may not be entirely surprising that at his follow-up interview Oliver tempered somewhat this positive assessment and described instead a perception that his depression is something that will require a level of ongoing or longer-term support:

> *I think if I am going to have counselling in any shape or form be it existential or CBT, I kind of wonder if a twelve week structure will kind of work. I think with the issues I am dealing with, it could be that I need to go back on a semi-regular basis for maybe 2 or three years, I don't know, just…just…I don't know how long.*(FU25)

Three months later and immersed in a manifestly depressed state, there was for Oliver instead now a contemplation of the depth of his despair and the conclusion that he needed something more enduring in terms of therapy. I think it is especially significant, however, that Oliver had moved from what I will refer to as his modality-bias. His prior knowledge of CBT as being the treatment of choice with the NHS informed him that it must therefore be the 'gold standard'. Other modalities were '*general counselling*' with the implication being that these were inferior, less specialised treatments. Now, however, he was saying something quite different. It emerges here that the relational experience, the being with another, is of considerably greater importance than the orientation. It is this, the meaningful relating, that he feels he needs more of.

Nonetheless, it is also important to highlight that Oliver, like Jawaad, left his therapy feeling that a key issue for him had not been addressed in the time allocated to him – namely his sexual addiction. Leaving the therapy with this frustration and disappointment, it would be difficult to see how this would not influence his thinking around the insufficiency of the twelve week model. My sense was that Oliver was saying to me that twelve weeks would have been fine had he addressed what he came to address, but his self-diagnosis of him being a sex addict had been dismissed by the professionals. Therefore in this situation his tendency to defer to 'the experts' had left him with a sense of a missed opportunity.

While some participants offered opposing experiences of what was achieved within the twelve-week frame, this being made explicit was undeniably provocative for all since in all cases it somehow influenced the work and outcome. For two in particular (John and Michael) there appeared to be significant and substantial insights gained which could be directly attributed to the imposed time constraint, lending support to a unique potential inherent in an existential time-limited setting. Perhaps above all else, however, is that the development of an early therapeutic alliance and particularly a desire for an issue-focused exploration by the practitioner were considered to be the fundamental prerequisites to a meaningful and useful experience.

4.3 Major theme 3: Leaving a time-limited existential journey

This final major theme captures the commonalities between participants in terms of what they left the counselling process with. Generally, there was a collective sense of this having been an exploration of how they are in the world and in relationship with others and self. Significant reflections were offered upon their experienced attitudinal shifts which they directly attributed to the therapy. Being offered the opportunity to review and look back as part of this research process was reported to be in itself of therapeutic worth and indeed without it, the implication was that some potential value from the therapy would have been lost. Finally the clear message from all participants was that this time-limited counselling was experienced as more of a start to a process of change rather than an end in itself – an important journey towards wellbeing had been initiated for them which they would now continue themselves.

4.3.1 Subordinate-theme: Purposeful living from adversity

Another pivotal aspect of this research has been to understand what, if anything, the participants had gained given they had now ended their therapy. As they looked back and assessed where they had got to, from all participants there was an almost tangible sense of them having found a substantively new way of being with self and others. Central to this current theme is that they reached this specifically because of confronting and attending to

the challenges that they uniquely faced in life. All had been met with substantial adversity in which the essence of who they were was characterised by despair and un-ease. By choosing to confront this adversity in therapy – and specifically ETLT - they immersed themselves in an exploration of being and from this they discovered at least the beginnings of a more vital and authentic engagement with life.

For all participants, I offer extracts from both the initial interviews and the corresponding follow-ups with the aim of capturing the reported therapeutic learning outcomes immediately on ending the counselling, as represented in the initial interview reflections. Then to also illustrate what this has meant in terms of how it has been integrated into life, if at all, based upon their reflections three months later, as represented in the follow-up interviews.

Michael explained in our first meeting that his counselling had in large part been focused upon defining and understanding his current attitudes and worldview and how these had been influenced by major life crises. His father, whom he had had a close relationship with, died suddenly. At the time, openly mourning for his father was actively discouraged by some in his family who told him that men don't cry which he feels this led him to suppress his grief. This was soon followed with Michael the virus being diagnosed as HIV positive. His was a late diagnosis and had already led to AIDS which was confirmed by his subsequent diagnosis of Kaposi sarcoma (a blood vessel lining cancer). For this he had to immediately undergo chemotherapy, which proved successful. Michael told me with much certainty that this had been a truly seminal time in his life. For one, it triggered an experience of acute clarity in which he recognised the opportunity for a new way of engaging with life. Confronting death (the real prospect of his own as well as the actuality of his father's) had led Michael to finally acknowledge the self-destructive path he was on, and to assume responsibility for his choices going forward. He spoke of how what had been his greatest challenges, times of intense anguish and despair, had also provided him with profound opportunities for learning and empowerment. Describing this in the counselling had helped him to clarify and articulate what this had meant for him:

> *Erm to begin with there was a negativity, erm I'm talking....you're faced with your own mortality basically...I mean that was a pretty bleak and negative time...but I can now*

> *see that how – and this will sound absolutely atrocious – but it kind of has been my saving grace *pause*... I kind of realise that now... That if it hadn't been for the diagnosis I would have probably been dead anyway *laughs** (II159-162)
>
> *Because it made you stop...* (Int)
>
> **interrupts* Take stock, take stock of what was actually...and take control of what was actually happening inside me...erm what I need and more of a focus on what I need to do in order to maintain my....'I am worth fighting for and I am not going to let this beat me'. Know what I mean? So that all came back.* (II163)

By being compelled to contemplate his death he ultimately concluded that he was already advancing towards self-annihilation by the heavy drug-taking and elevated-risk sexual behaviours. Michael's internal narrative was that he was worthless and so not worth protecting or respecting, but when faced with death, he realised that he wanted life. This was a journey from despair and hopelessness to one of hope and vitality, one of assuming responsibility for his wellbeing and indeed now coveting health. An especially noticeable reflection from Michael in this extract is his sense of the HIV as his '*saving grace*' – a moving paradox of how being confronted with one's own mortality served to rescue him from self-destruction. I had a real sense of Michael's hunger for life, and what I heard to be a genuine acceptance and respect for his right to inhabit space in the world.

Notably, however, these were not new revelations necessarily emerging for the first time now. What this counselling primarily appeared to do was to refresh or reacquaint him with already learned but a somehow lost appreciation of and engagement in living life with vigour and purpose.

As I waited for Michael to arrive for our follow-up interview, I wondered if this reacquainting with more intentional living would yet again be blunted during the passage of time. In fact Michael provided me with an example of a positive outcome from the counselling which was continuing to develop which he appeared enthused by. Specifically, he referred to the self-loathing that so crippled his ability to engage in the world and how he felt that this had been significantly addressed, which he explained by referring to a newfound relative ease in entering public spaces alone:

*And....not being so apologetic for, not wanting to sound too dramatic but, for my existence *laughs* You know what I mean? So...yeah it has helped*. (FU25)

What do you make of that? What has changed in your thinking to get to the point of 'I'm not going to apologise for my existence'? (Int)

*Erm...just a maybe a little modicum of self-worth or recognising that I'm not the things that I was essentially projecting onto people that I thought the way that they saw me. Does that make sense? (*interviewer nods*) Erm I would...I would automatically anticipate what another person's judgement would be of myself and I would project that and I would therefore act out the clown. I would act out the stupid, like they want, cos I thought that that was what they'd want me to do. Therefore it was kind of like softening the blow in a way, so that if I do make a blunder or say something that's out of turn, bit of a faux pas erm I'm therefore cushioning the blow...So yeah, I know not to do that now as much and what I say is valid and can be taken seriously. And being perceived as such that kind of hurt and of course the longer that goes on, I start to believe it. And so the counselling has sort of broken that cycle a little bit.* (FU27)

The above reflections from Michael provide further revealing insight into his worldview as he began and crucially how it had been transformed by the counselling. He adopted a comedic persona since while he may be mocked, he at least had an identity and role within the group. In other words, he had worth (to amuse others) and so he would be included, he had deduced. However, Michael also realised the self-destruction inherent in such inauthenticity. By telling himself that he was only acceptable in this way, he essentially had served to deny himself as a complex human being with needs and wants of his own. By concluding that his purpose was to fulfil his assumption of what others thought of him ('*the clown*') and while his payback was that he gained an element of self-protection for himself ('*I can mess-up and no one will expect different*'), he had engendered a self-fulfilling prophecy that contributed to the erosion of his self-esteem.

The counselling facilitated him adopting a more affirmative view of self; certainly at least challenging his doubting the validity of his being. Michael was now effectively asserting his right to be seen, to be heard and put simply, to be. Of course implicit in his dialogue is that he is not entirely free from this doubt (for example '*...as much*....'*sort of*'), but it had been nonetheless challenged significantly and to the point that he has at least access to an

alternative perspective. In telling us that he gained precious, albeit a small amount of, self-esteem (‘*modicum of self-worth’ ...’a little bit’*) he is maybe telling us this is work in progress but it is a significant gain nonetheless and he was now moving in the right direction.

For John, as he knew from the beginning of his process, his was a journey about integrating his new reality:

> *I think that's what I learned - that it can’t be fixed and that is hard for me because I'm kinda this person that thinks 'oh there has to be a solution' but accepting that... you know *whispers* sometimes there isn't.* John (II77)

The whisper felt significant– was he letting me in on a secret, one that he has himself been let in on? Or, as I experienced it, it expressed his sadness and was as though to soften the blow of such harsh but irrefutable news. John had realised that this could not be about undoing or fixing the circumstances that he was now in, that would be futile. It was only John’s attitude that could, and needed to, change. This brief extract above I think captures succinctly John’s substantial progress towards a fundamental acceptance and integration of his diagnosis.

Similar to Michael, John expressed a newfound optimism and an embracing of life. He described recognizing the importance of the here and now; that life was about engaging in the present since fundamentally this was all that we had:

> *And I'm gonna live and you know there's that slight fear of well...‘what does the future hold? Where and how will it go? You know medication will I have to go on that? How will that go?’ But generally you know that's probably two or three years down the road...and what's the point of worrying about that? The counselling helped me realise that it's very much about today. It’s today that matters.* John (II93)

A series of questions about what will life be like were readily accessed, they were present but the panic and despair that they had induced before has been replaced by an apparent ability to bear uncertainty. The task now was to be more mindful of the present and less future-focused since that is speculative and unknown. Ahead there are many unknowns, possibilities

and challenges for which he does not have the answers– the focus is instead learning to accept uncertainty and crucially to live more in the here and now.

I subsequently looked at the follow-up interview to see if and how these initial realisations, just one week after his counselling had ended, had manifested or influenced his life some months later. What clearly emerged was an engagement with what it means to be authentic, both with others and with himself. John explained that by recognising and being true about his feelings, rather than stifling or concealing them when it may feel unpalatable for the other, had afforded him a sense of empowerment and enablement:

> *Yes. To realise that I was limiting myself by not actually saying things to people. Like in relationships not saying how I was feeling now, but building it all up in my head until I found a solution or some idea, but instead learning to say 'actually I'm feeling really annoyed right now, I don't know why'. Just immediately removes that feeling, that anxiety, because I am being honest with the person, I am being genuine. 'I'm irritated...I'm annoyed', just to say that.* (FU90)

John had learned the importance of communicating his feelings in the present ('*right now*') and experienced how this had opened a more emotionally intimate way of engaging with others. Much anxiety resided in lying to protect the other, but this had been readily alleviated by being honest and authentic. John alluded here essentially to a paradox in his life that had been to the detriment to his wellbeing: that in his ardent quest for acceptance by others, he had lost the sight of himself, his needs and feelings. To now be challenging this represented a substantial shift and therapy outcome. He reports moving to a new way of being in which he is able to communicate his needs and wants and express his feelings. They are valid and so he is valid.

Oliver also revealed gaining much clarity around what the impediment was to a well-lived life. The counselling confirmed for him what he wants in life in terms of his career including how far he is from that and what his fears and obstacles are to achieving his hopes and potentials. He explained:

> *Erm I would say what emerged is that I'm still definitely in a job that I don't like, it's not what I want to be doing and it (counselling) did help me identify...even although I*

> *think I already knew it...but it helped me confront the fact that I'm very frightened to leave that job, erm for the security, erm for the fact that I would miss my colleagues, I really like them. But that I am too frightened to kind of take a leap into the unknown, and I could perfectly you know, the way I am going, I could end-up doing this job, which I like, but am not fulfilled by, for the next five or ten years, without changing errrr....and then looking back and thinking 'well if only I had taken a chance and tried something else might have led to me to what I really want to do'. So I think (counsellor) was really good at kind of really, I wouldn't say drumming that into me but kind of getting me to really kind of recognise that and acknowledge it.* Oliver (II71/2)

The therapy therefore was fundamentally about describing, clarifying and contemplating alternative perspectives. The key realisation for Oliver was that his fear of engaging with the unknown and by living a life in which he minimised risk as much as possible, he was not engaging with life to full potential. He reports his greatest fear is to regret, to look back and realise he has not lived, an outcome that could most possibly if not probably be realised given his current way of being. The counsellor facilitated a wake-up call for him in so far as he was now acutely aware of what constituted for him an unfulfilled life. As he departed counselling, Oliver had not implemented change in his life, but he had a new awareness of the choices he possessed and the responsibility to himself to create a meaningful life.

At the follow-up, on enquiring how the counsellor facilitated this new awareness for Oliver, he recalled a question from her around how he would feel if he were in the same job and situation five years from now. A question that evoked a lot for Oliver since it essentially encapsulated and unearthed much of his existential crisis:

> *Yeah that was very crystallising for me, cos i thought that is not an attractive proposition but at the same time those are important things... And I think this is really important for me to take stock of. You know for me to pursue the creative things as an artist whatever it kind of requires me moving out of my comfort zone be that by reducing my hours or finding another job. And the security thing is a big deal for me and I think a lot of that goes back to my relationship with my parents and erm what they expected of me erm. There is lots of things you can really pick out of that cos another big thing that has been getting me down is that I don't have lots of friends and I am becoming more cynical and less trusting of people and you know I am not moving on and meeting new people and that is worrying for me erm and getting me down a bit. Well quite a lot. So yeah it's a strange one cos it feels like the therapy was quite a broad thing but there is an awful lot of important things out of it*. (FU63-7)

Oliver was effectively being invited to confront uncomfortable realities by having his sedimented worldview challenged and in doing so he was furnished with at least the option of an alternative engagement with life. He was aware of the tension between job security and the passion of his creativity, as well as the influence of his parent's expectations and values. Indeed their attitudes persist as both omnipotent and stifling factors as perceived by Oliver. His assumption of their rejection if he were to be truthful about his sexuality traps him in an isolated and lonely life. In the first theme (1.1) I referred to Oliver's predicament as fundamentally one of not being free; of holding a deeply judgmental attitude towards his sexuality manifested in his not engaging with the world authentically for fear of being rejected were he to reveal the 'real Oliver'. Now, some three months after the counselling had ended, largely his world has not changed - he continues to spectate in life, fearful of the risk in participating. What has changed is his awareness, something that only from articulating, as he does in the above extract, does he realise the depth and fundamental importance of what was unearthed and realised in the counselling.

For Jawaad, the counselling had also been about understanding his way of being in the world. His was an exercise in understanding his values and how these being challenged generated conflict and dissonance. He had endured a hostile work-place, his family lived abroad and did not know he was gay (they would not approve, he expected). These factors all contributed to his sense of profound isolation and whose life had been so heavily impacted by his carried shame. Feeling worthless, he sought validation with multiple sex partners. The counselling offered a space to make sense of how his life had become as it was and, crucially, how he could survive painful emotions:

> *we had come a long way and we had identified what I needed to do. It wasn't solutions I want to emphasise that. That's not what I was looking for – or maybe I was at that time but that's not reality. You will have these feelings move in and you need to cope with them.* Jawaad (II210)

Therefore the counselling was about learning to live with adversity, an inevitable and unavoidable aspect of the human condition. Jawaad is describing here effectively the essence of a deliberate engagement with life: rather than to try to flee from difficult feelings, to instead know they can be both experienced and survived offered a far more empowering way

of being. Notable also in the above extract is that Jawaad comments on the significant ground that had been covered in the therapy, which appears to be in sharp contradiction to the previous themes (in particular 2.3 where he describes his therapy as effectively a lost opportunity). It is perhaps revealing that when I was not explicitly asking the participant about the counsellor said or provided, he seemed inclined to offer more positive assessments of what the therapy addressed.

Jawaad expanded in the second interview upon his suggestion that his crisis had afforded him an opportunity for learning about himself and in particular his capacity for enduring. A key outcome was that he had learned to become more aware and attuned to his needs and values:

> *Yes and a learning curve around this was when I went to an interview for another organisation, and it was exactly the same scenario and that is why I have no regrets because I was able to say 'no I do not want to be a part of that'. I made an informed decision not to be a part of it because that went against everything that I believed in and following my intuition. When I came out of that interview I was shaking because I felt I knew what the outcome could be, and before I had had the same intuition but I pushed them aside and didn't ask the questions that I should have and read the signs. But I did this time...At the expense, at the chance of putting myself of not having a job... But I chose at that point my mental health, the state of my mental health, over...financial.* (FU39/42)

In this extract Jawaad presents himself as someone who was now making decisions mindful of his responsibility for his wellbeing and aware of his embodied reactions rather than dismissing these cues as he had previously. It is of course possible that fear of a repeat of his previous experience in a similar workplace was his main motivation in declining this role. Nonetheless, what is evident here is a newfound self-care, as well as an acknowledgment of his capacity to cope in situations. Jawaad had moved to now living his life more attuned to his worldview. Incidentally it emerged in our discussion that Jawaad has found new employment working for a charity in a role that he was very much enjoying.

Emerging from all transcripts was a sense of each participant leaving their process equipped with at least the knowledge of how to live their life deliberately and more attuned to their needs. Therefore a process of self-acceptance, which each had identified as they

underpinning objective from therapy, had been at least instigated. There appeared to be a more acute understanding and appreciation of what a well-lived life looks like and how that might be achieved and maintained. For all participants this had first and foremost been a process of describing and clarifying, and focused around meaning-making rather than symptom alleviation. Learning from adversity required listening to the message and understanding the source, something which their time-limited existential therapy facilitated.

4.3.2 Subordinate-theme: The value in taking stock

All participants referred to a therapeutically beneficial effect from taking part in this research. Having the opportunity to reflect upon what had happened for them during their counselling brought to awareness their therapeutic outcomes. The inference from some at least was that without this opportunity for looking back, the experience and so effect of change may well have been diminished. The supposition emerging here is that by assessing and appraising with a third party after the completion of the counselling contract - analogous almost to an external audit process - was universally identified as an enhancement to their process. By taking stock, the participants were afforded a space for clarification and consolidation both of which may not have occurred had they not spent this time reflecting.

At the beginning of Jawaad's follow-up interview, he readily expressed the value he had attached to our first interview together:

> *I felt that I wanted to see you again. Erm...because it was quite helpful and useful for me in a therapeutic way. Being able to talk it through. Obviously this must be your profession so you were able to bring out...you were able to talk to me on a level that I could understand. So it was very useful for me. And I wanted more*. (FU1/3)

This was to an extent then an unpacking of what had occurred in the counselling. By creating a narrative for the experience he could perhaps gain fresh and deeper perspective. In both interviews with Jawaad, it was very evident that much had been left unattended for him from his counselling process. He was holding strong emotions about it generally and particularly about his therapist, as has been conveyed in previous themes. Noteworthy in the above extract is his experience of me conversing with him '*on a level (he) could understand*'

suggesting he had a sense of inaccessibility around their dialogue, certainly it is a further indicator of the sense of disconnect that he experienced between them.

The general complimentary tone about our meeting and specifically about me also seems significant and requires some consideration. Firstly, supporting the thrust of this theme, it is evident that Jawaad got something of value to him since he '*wanted more'*. It would seem reasonable to assume that at least on one level, what he got was as he reports – the space to make sense. For me, taking into account Jawaad's context of discrimination in the workplace by his line management, I have since wondered if I had provided in part a space akin to a corporate grievance process. While such a procedure had eluded him in his job, here now I had provided him with the opportunity to air his retained anger about his therapist and for me to bear witness to this 'injustice'. I am also mindful of the ethical perspective here; the question for me was had I been providing a space that was being construed as therapy for Jawaad, rather than (or as well as) research? My supposition is that there was certainly something intrinsically therapeutic about the very process of reviewing his counselling with a third party.

Indeed this notion of deriving benefit from an 'external' review was explicitly referred to by John. For him this exercise of reflecting provided him with an enhanced clarity and fresh perspective:

> *Well it clarified things for me. Just to kind of do a review in a way, it was kind of in a way a more formal ending in a way...to the counselling...I can't explain it, but it did do something for me. And I suppose I left in a very positive note and in a very good place and I can't really remember what we...we really just talked about my experience of the therapy and what this therapy did. Yeah and I was quite clear what the benefits had been. But it almost allowed me to reflect outside of the counselling relationship, do you know what I mean. Because it's part of a study it gives a different perspective.* (FU2/6)

Again the participant is clear that there was therapeutic value in appraising his experience. Part of the benefit made explicit is the associating of the interviews with the ending of his counselling. For John, these interviews had essentially been a meaning-making process of a meaning-making process, evoking the concept of the double hermeneutic inherent in

interpretative endeavours. Equally evoked is the hermeneutic circle if we consider his sense of stepping back, outside of the phenomenon – this was a piece of research in which he was being invited to stand outside his experience and look at it as a whole as well as unpack and look at the specifics. I am again mindful here of John being a therapist himself and so perhaps more inclined to such an exercise. Nonetheless, John is saying that this process of reflecting provided him with something that perhaps cannot be quantifiable beyond saying it '*did do something*'. Again, there is a parallel here with a therapy process in that the participant is left with a sense of something perhaps transformational or meaningful having occurred but which cannot be readily articulated.

The research interviews offered Oliver a chance for him to analyse the process in a way that he had wanted to do during the process but had dissuaded himself from, as he explains:

> *This is a really interesting conversation cos in a way it's the conversation I always kinda wanted to have with (counsellor), but I avoided it because I thought, 'well not while I am having the therapy perhaps, I shouldn't really, don't get too analytical about it, just go with it'.* (II190)

Oliver is tentatively suggesting that the separation between being immersed in the therapeutic process (living the actual experience) and reflecting upon that process are perhaps a necessary delineation. Linguistically, him recounting the instruction to himself reveals not only his desire to optimise the therapeutic potential of the therapy but also suggests an implicit constraint in that he seemed bound by there being a *right* way of being in therapy. This correlates with his early decision when beginning his counselling (and reported in theme 1.3) to avoid sabotaging the work by analysing it. Equally, however, he seems clear that significant value exists in assessing the experience, albeit afterwards.

Given this reflection, I asked Oliver if there had been any conversations at all around the process or what was happening between them in the room. His response revealed his reluctance and discomfort around such an exploration involving the other:

> *Erm I don't think we did, I have to be honest I'm not very comfortable about talking directly to someone about how I feel with them. I have a friend who really likes that*

> **laughs* she always likes to talk about things like that but I kind of go with it, but personally I don't feel comfortable with that kind of conversation. But I wondered if maybe we should have, *counsellor* and I, but we didn't.* (II191)

As with John and Jawaad, Oliver points here to the value of a review that is specifically external to the counselling. What is implicitly being revealed here is the anxiety with being candid with the therapist about his feelings towards, and experience of, them. There is a danger and intimacy in candour which, and again mindful of the presenting context, may have felt simply too challenging. That Oliver was left with wondering if perhaps there should have been some level of process reflection between them suggests that without it, something important had not been attended to.

Prior to the research interviews, Michael had been left with a significant feeling of pointlessness around the counselling:

> *I am glad this has happened (research interview), because it has kind of crystallised the whole process. But had you not been doing this study I would not have had that so that's the only thing that sticks out in my mind is the finishing of it and you are just left to get on with your life and it's not... and it is that uncertainty, you know 'what the hell just happened *laughs* for twelve weeks?!' 'What have I actually achieved if anything, what have I actually covered? Have I covered this, have I done this?!'* (II143)

As with John, there appeared to be the sense of a more comprehensive process and ending for Michael by having this review. Had he not participated in this research, it seems probable that he would have felt adrift and abandoned. This incidentally also infers his perception of a lack of appropriate compassion conveyed in the manner of ending. The counselling was left unfinished for Michael; he had been left with a level of confusion and lack of clarity around his experience. Therefore without this research process his sense is that this would not have been achieved and as such possibly resulting in a lost opportunity for therapeutic gain.

As reported in the previous theme (3.1) Michael had described fundamental shifts in his experience of being with self and others, and a new attention to his needs and boundaries, all of which served to fundamentally develop a more meaningful engagement with life.

Looking back in these interviews, reflecting upon what had happened – to understand it, appraise it and bring to his awareness what he had achieved had an affirming affect:

> *Yep and it took someone to question what...someone who knows what the counsellors are set out to achieve, I mean just that one conversation that we had made me think 'oh my God, no I have you know taken away a lot'. Yeah and it kind of keeps the continuity as well in that it kind of, that level of care, it seems a bit more personal you know? I mean rather than just you're shunted in and shunted out of the system and that's it.* (FU22-3)

Michael is also disclosing here residual dissatisfaction and anger with the nature of the ending of his counselling. Being followed-up and asked for his views evoked for him a perception of professional after-care from the service that felt tailored to him; the implication of course being that without this experience in taking stock, an impersonal even de-humanising impression could have been inferred.

To bring together the findings in this theme; one of the salient commonalities to emerge was that conducting a review (as this research essentially was) in itself conveyed an impression of a more comprehensive and tailored service. By being asked to reflect and for feedback, each participant reported feeling both more supported and valued by the service, both of which were of significance again considering their presenting issues. Crucially, however, was that the interviews were conducted by someone other than their therapist (although also important that it was by another practitioner). The clear message was that this was especially welcomed suggesting it facilitated a more candid and comprehensive appraisal.

4.3.3 Subordinate-theme: The beginning in the ending

As has already emerged across this analysis of the participants' journeys, each of them had discovered to some degree a new way of being in the world. Indeed perhaps only with the exception of Oliver, all have described an already transformed and invigorated engagement with life. However, as implied in the title of this subordinate theme, the therapy was a means of instigating a process of discovery that would persist beyond the confines of the therapy room. All participants reported leaving the therapy less with a sense of completion and more of a view that a process of change had been initiated - be that change of behaviour or attitude,

or both - which they were now continuing themselves. This was the first, albeit pivotal, leg of a longer journey of discovery which they were now embarking upon and which for now at least, would be travelled alone. This was not relayed as a problem or criticism of time-limited therapy but instead a pragmatic reflection of what could be realistically achieved in this timeframe.

John had moved from a place of chaos and crisis to one of calm and coping but was mindful of this being work-in-progress. In the following extract he describes this sense of a process beginning rather than ending:

> *I think it (counselling) has erm kicked-off something which I am continuing myself. I've really felt that - it hasn't just stopped…It's there with me and that's something that's changed in me and that's something I want to keep. I don't want to lose that...I found something here in me that I want to keep.* (II143-4)

The evident anxiety around how transient or temporary the change might be reflects how much it has mattered to John. In this short extract he alludes to both something found which he does not want to lose and to something having been changed that he wants to maintain. He also refers to this '*something*' as an entity in itself that is by some means accompanying him or that he has instilled but also suggests it is an integrated part of him, the change is '*in me'*.

Considering this holistically and again within the context of how John began therapy and the journey he then immersed himself in, he was first lost in a state of crisis and isolation, and then discovered a state of coping and relating. His attitude to himself had been challenged, from which one outcome was a greater attention to his needs and wants. Although by the time of the follow-up interview, this somewhat upbeat appraisal of where he had reached was to some extent tempered by the impact of subsequent challenging events occurring in his life. However, he added further context to what for him had been achieved so far, and again what was identified as effectively work-in-progress:

> *And there was stumbling blocks which I was really challenged by since the therapy that have really rocked me and I feared would put me back in that same place again...but they haven't. And I suppose again it has challenged me to now make the changes that I am now aware that I need to make. That I have gotten to that place that I had the*

support that I needed, the caring and understanding that I needed, the space to get my head together, and that has brought me to 'now I need to change what I want to change'. I need to do it slowly but I will do it, the judgement has been removed I suppose, I'm not as judgemental on myself. (FU14-15)

John is saying he is not yet where he wants to be and he knows he must make changes in order to move towards a place that will enable and facilitate a well-lived life, but he will do that in a spirit of self-acceptance. Evoking and embodying a felt sense of having already travelled to a new, perhaps transitional, place, John has discovered that he can endure adversity in his life and not relapse or have his progress sabotaged. This has also informed him that he is ready and able to make more substantive structural changes to his life but at a pace that is respectful and attuned to his emotional capacity and wellbeing. Significant also is his latter assertion that he will change what *he* wants to change – this will be of his volition, of and at a time of his choosing. Considering this against a milieu of John being so impacted all his life by what society and others told him about how he should be, and how he should not be, feels for me a very encouraging narrative.

For Michael, there was some frustration in not having a prescriptive therapist from whom he could walk-away with effectively a 'how-to guide' for living. However, by experiencing the more facilitative nature of his therapy, a sense of himself navigating towards a new way of being was engendered:

I expected a magic wand, erm 'I am going to change you' (FU70)

'I am the expert'...? Int

Yeah 'and you are a mere mortal' (FU71)

So what is that like now, having had a different experience? Int

*Erm, well part of me would still like the expert of course *laughs* but again...I am on the right path in terms of I know that a lot of this is down to me and not down to anyone else in order to make that change. So no one else can make that for me. But nor am I kidding myself that I have all the answers or...or that this is a walk in the park, far from it, but you know I quite like me *laughs* so, a bit like that ad (television commercial)...'I'm worth it!'* (FU72)

Michael is en route to somewhere and crucially he has assumed responsibility for reaching his desired destination. He had hoped to be rescued but now recognises that only he can do this – it is he that is uniquely placed to understand and implement what he needs. Therefore this was about assuming responsibility for self-care, nourishment of self and shaping a well-lived life. Michael has assimilated that only he can be the architect and arbiter of that. Considering that Michael had described utter hopelessness and despair as being familiar moods for him, this optimism about life and his place in it is quite striking. In the room with him his fired-up energy felt almost tangible.

Therapy was not only an ongoing process beyond the end of the twelve-week contract for Jawaad but had, he noticed, also been ongoing between sessions. His contemplation and reflection of what was being explored largely happened outside of the room. He offered a specific example to explain:

> *There was a situation where I met someone, during the counselling weeks, and I was falling for him and he was for me and then one week I changed my mind and ended it. I could not make the leap. And she (therapist) asked me 'what is it about that leap? Being able to make that leap...to get there?'. And that was a lot of conversations *laughs*... And I have continued to explore that question on my own a lot. It didn't stop with the last session. It never has. There's always things going on in my head following each of the sessions in fact, and of course since. But you don't necessarily reach a point where...because I can start the thought process but then where? Who am I going to bat that to? It's like a game of tennis. I am batting and batting but there is nothing coming back.* (FU123-6)

This ongoing processing was not without limitations for Jawaad. He portrayed an unsatisfying aspect to such a questioning by and of himself without feedback or perspective from another. That Jawaad identified as a key aim in his life (and of the therapy) was for meaningful interpersonal relating with others may perhaps go some way in explaining this somewhat conditional endorsement of solitary contemplation. As in therapy, he wants to talk about his life story and hear what the other thinks. That said, in offering in the above extract the example of how questioning from his therapist particularly resonated, he encapsulated the very notion of an ongoing process.

The concept of being 'in-process' as conveyed by Jawaad, Michael and John, was less certain for Oliver. Whether or not anything substantive and enduring had occurred for him was something he felt still too close to the experience to adequately assess:

> *I think I'd have to come back in a year and say, having had some distance... Yeah and see where I get to in six months, a year or something you know cos sometimes people will say things and it won't impact you straight away but then yeah sometime later it will kinda come back to you or something will happen that will connect with something that was said you know that was talked about in therapy some time ago.* (II53-4)

However, this reflection in itself seemed to also imply that there was at least some kind of ongoing processing of the therapy experience for Oliver. He was suggesting that change, or perhaps more an awareness of change, takes time. Insights or interventions made during the sessions required time for them to be absorbed and made attributable and relevant to one's life. So it is started in the therapy but not yet integrated.

At his follow-up interview he still felt unable to adequately assess (*'I kind of think it might be a year or two before I can sort of step back and say 'that was what it was about''* Oliver (FU10)), but nonetheless, seemed clear at least that *something* occurred during the therapy for him. What that was and how significant that would prove to be, only a more significant passing of time and living of life would determine.

To sum-up this final subordinate theme, the existential time-limited therapy offered was not experienced as the end destination in itself for any of the participants. They all expressed some sense of this being essentially a starting point, albeit a fundamental one, to a longer ongoing process. A starting point principally in that the possibility of a new relationship with self had been revealed and instigated. This was not experienced as a shortcoming of the time-limited setting but more so a pragmatic acknowledgement of what can be achieved in twelve weeks. There appeared to be substantial and positive therapeutic outcomes for each of the participants, although Oliver notably remained cautious and tentative at his follow-up interview particularly about whether or not any progress so far would prove to be enduring.

Notably, across the transcripts, there emerged a common sense of each assuming responsibility for continuing their individual processes beyond their counselling.

In the following chapter, these findings will be discussed and evaluated within the context of the extant literature, and the implications for counselling psychology practice will also be made explicit. Before doing so, however, I include below some additional thoughts around ethics in conducting these research interviews.

Interview reflections from an ethics perspective:

In Chapter *3* (section *3.4*) I discussed the ethical dilemmas often faced when interviewing participants in counselling psychology research. As part of this, I referred to Duncombe and Jessop (2002) and their warning of the '*commodification of rapport'*; utilising one's skills as a practitioner to essentially engineer a sense of affinity and empathy for the purpose of eliciting 'good' data. It was certainly my hope that the participants would engage in the research interviews as fully as possible and to this end, it would be disingenuous to suggest I did not invoke my relational skills, which have been honed as a practitioner, in order to facilitate my aims as a researcher.

First and foremost, it was important that the participants could be assured that this was a responsible, professional and safe environment; something which in my view is conveyed by how the researcher conducts both them self and the actual process. Further, I did in fact experience a sense of affinity with my participants which I accept could have been conveyed at times, for example, in my comments and prompts. However, this was not 'engineered' for my progressing my researcher aims and instead I suggest this is an inevitability of authentic relatedness when two people are engaged in a meaningful exploration such as this. Nonetheless, and of the upmost importance, I was transparent throughout in the purpose of the interviews and in my role as researcher.

As Brinkmann and Kvale (2008) argued, research such as this involves a degree of acceptance that there will be some tension and conflict in terms of researcher-practitioner aims and potential effect for the participant. That is, it is not necessarily about trying to eliminate these

tensions, a task which in itself could simply paralyse the entire research endeavour. Instead, the primary ethical duty is to monitor and recognise dilemmas and risks when they do emerge, identify where the associated dangers might exist for the participants - and then manage these accordingly.

To this end, it was extremely important that each participant was aware and felt assured that they were being asked to disclose only to the extent that they felt willing to do so. Therefore, I purposely reminded all participants before *and during* each of the interviews that they could terminate them at any time. It was also crucial that the opportunity to debrief both with me (as an accredited practitioner) immediately after the interviews had completed was afforded, as well as ensuring they were fully aware of the option of alternative counselling support should they wish to access it.

One specific theme that has emerged is how the participants experienced the interviews as being in themselves a pivotal component of their therapy journey (see section *4.3.2*). This was principally because they provided them with a defined space to reflect, take stock, clarify and articulate their outcome appraisals, external to the actual therapy. Examples of this are especially evident with Jawaad, who reported a challenging experience with his therapist and spoke of his research interview as being '*very useful…(and so) I wanted more*'. Equally with Michael, who thought that without these interviews, he would have been left feeling adrift post-therapy. Incidentally, since there were two interviews conducted with each participant, it is my view that this yet further enhanced and developed the sense of after-care and consolidation of outcome that they expressed.

Certainly, the participants' experiences of this research process portray a somewhat different purpose (and effect) of the interviews than mine, as researcher. My intention has indeed been to produce robust data from which to develop a particular contribution to counselling psychology knowledge and practice. This was made explicit in both the Participant Information Sheet (PIS) and in the initial email and telephone communications with each of the participants, as was the possibility that engaging with this subject matter could provoke uncomfortable feelings for them. Therefore, it is reasonable to assume that the participants

were cognisant of both the intention of the research as well as the potential impact of taking part in it from the outset.

Moreover, since I was asking participants to reflect at length and to considerable depth about a very recent therapy experience, my view is that it was in fact highly probable that there would be a therapeutic effect from such a process. The very nature of engaging in why one sought help for problems in living, what that help was like (indeed if it helped at all), and how one now feels as a result, by necessity invites an exploration of thoughts, feelings and behaviours of both then and now - the very thing we also do in therapy. In other words, I suggest there was an inexorable overlap in both process and so also effect given the subject matter being researched.

This is not to imply that therapy sessions and research interviews are the same. They have, of course, profoundly different aims and intentions. However, aspects have been shown here to have substantive similarities in terms of experience and potential effect for participants on account of the research topic. What is most important, therefore, is to consider and assess any risk of harm to my participants that emerged as a result of their taking part. While each reported the interviews as being an unequivocally positive and complementary component to their therapy experience, there could well have been potential for upset in the reflecting upon unhelpful or poor experiences within the therapy as well as upon their actual presenting issues.

Again, Jawaad in particular comes to mind given his especially difficult encounters with his therapist in the earlier stages of their contract. However, had he not had this arena in which to review his experience and articulate his un-ease, what unattended emotions would he have been left with after the therapy? What potential risk of harm may this in fact have presented? In these interviews, Jawaad had been provided with an opportunity to express his evident persisting anger and, crucially, for this to be heard in a contained and reflective space. Indeed, as shown above in his account, he found the interviews to be of considerable worth in this regard. Equally so, what effect on Michael with his sense of being '*shunted in and shunted out*' of the therapy process, without this opportunity to appraise? My argument,

therefore, is that while there was an unintended but clear therapeutic effect from these interviews, there is no evidence of harm; instead they were experienced as being of substantial worth by all participants.

I turn now, in the following chapter, to a detailed evaluation and discussion of the findings presented in this chapter by way of then explicating the contribution to knowledge that this research offers.

5. Discussion

Chapter scope and objectives

In the following sections, the research findings presented in the preceding chapter will be evaluated within the context of the existing literature and the implications for clinical practice will be made explicit. While it is not my intention to repeat that which has already been discussed in the preceding chapter, I do make reference to the subordinate themes throughout for the purpose of transparency and clarity of argument. This chapter concludes with an assessment of the research limitations as well as offering some ideas for future research.

I begin with summarising the rationale that has underpinned this project: given the ever-increasing prevalence of time-limited therapy provision in the UK, for ETLT to be included for consideration by policymakers and service commissioners, the current lack of ETLT process research must be addressed. By way of providing experiential accounts from participants who had recently undergone existential time-limited therapy at an HIV counselling service, this research is intended to offer such a contribution.

The primary aim has been to gain an understanding, through these first-hand reflections, of the defining features of existential time-limited therapy and the extent to which, if at all, it attended to the participants' needs and objectives. To this end, and based upon what emerged in the findings, I have structured this chapter to systematically address each of the five research aims developed from the rationale, as outlined in Chapter 2 (*section 2.6.1*). To reiterate, they were:

1. *Presenting issues and objectives - what were the participants' hopes and expectations as they began the existential time-limited therapy at HCS?*
2. *The therapeutic process – what, if anything, actually emerged for the participants during the therapy contract*?
3. *Outcome - what, if anything, did the participants take from the therapy and how have they been affected by it?*
4. *How did the participants' experience the therapeutic relationship in this setting?*
5. *The time-limited frame - did this influence the work for the participants in any way and if so, how?*

The first three of the above are primarily interested in what the participants were looking for and, basically, whether or not they got it. For this reason, I address these together as being essentially about the *relevance* or suitability of the existential approach; in terms of attending to the participants' needs and objectives. With regards the fourth research question – the therapeutic relationship – much emerged in the findings confirming the importance of this, and in particular *how* it was experienced as such. Finally, and in addressing the above fifth question, the time-limited frame was of course a key characteristic of the service provided to the participants and indeed also a central aspect of the research rationale.

I have, therefore, identified three broad areas for focus which are based upon these five questions and the subsequent analysis of findings:

1. *relevance* of ET in terms of attending to presenting issues and achieving desired outcomes (section 5.1)
2. the particulars and influence of the *therapeutic relationship* (section 5.2)
3. how the *time-limited setting* affected the service provision (section 5.3)

While addressed separately below, these three areas for focus are all inter-related and interdependent and as such each section below should be considered within this wider context. For example, the suitability of existential therapy cannot be evaluated entirely separately from the frame in which it was conducted nor indeed from the relational factors that are such a defining feature of the existential approach. Equally so, the effect of the time-limited setting cannot be fully understood without taking into account how this influenced the therapeutic relationship or how the relationship impacted the pace of sessions. Therefore, it is crucially important to emphasise that by presenting the sections below as I do, it is done all the while mindful of their interdependence and interrelatedness. However, it is also the case - and evoking the hermeneutic circle that underpins the methodology of this research - that to understand the whole it is necessary to consider the component parts of which it is constituted, and vice versa.

I turn first to the relevance of the existential approach from the perspective of the participants presenting issues and objectives.

5.1 The relevance of the existential approach

This first area of focus explores the suitability, or relevance, of the existential orientation in terms of addressing the presenting issues and objectives of the participants. That is, against the context of existing literature and research, I consider below the implications from how the therapy was experienced. To this end, in section 5.1.1, I discuss what the therapy was for (as principally reported in the subordinate theme '*A quest for acceptance*'). Subsequently, in section 5.1.2, I reflect upon how the existential therapy was experienced and how it sought to enable and facilitate this quest; and for this I draw particular attention to the findings in a '*Meaning-revealing journey*' combined with the reported therapy outcomes in *'From adversity to purposeful living'*.

5.1.1 Participant presenting issues and objectives

It was readily evident across all participant accounts that, as the participants began, each was experiencing a pronounced state of inter-relational anxiety. These were not issues

symptomatic of intra-psychic struggles or disorders but rather they were about relatedness, being-in-the-world and being-with-others (Heidegger, 1962). Specifically, and while to varying degrees of intensity, all conveyed an underlying sense of 'unacceptability' in terms of their way of being in the world sexually; as experienced in their personal, social and professional contexts. The participants collectively conveyed a sense of low self-worth, isolation and loneliness; all of which were associated with anticipated or actual rejection and persecution by significant others. The findings are therefore reflective of previous research that has shown, for example, that rates of depression and anxiety in LGBT people are elevated (King & McKeown, 2003); and crucially, that these are considered to be indicative of the common adverse experiences associated with LGBT sexuality (Richards and Barker, 2013).

The consequent unease the participants felt was manifested in an embodied sense of shame and guilt around their non-conforming sexual desires and behaviour. Malyon (1982: p.68-69) referred to a profound existential crisis that is '*especially potent for gay men...(and is) the result of social values and attitudes*' and this would certainly seem to be reflective of the participants lived experiences. Perhaps such an existential crisis is in some ways inevitable for self-aware minority groups who stand apart from the seductive comfort of the conforming majority that Kierkegaard ([1844]1944) and Nietzsche ([1883] 1962) referred. Nonetheless, writing this research some thirty years later in the United Kingdom, it is notable that Malyon's words seem as relevant today to my participants' experiential accounts as they did then, despite substantial political and legal advances with regards inclusiveness and equality.

A further key underpinning of the presenting issues was the participants' relationships with HIV. Specifically, their lived experience of either having an HIV-positive diagnosis, or in one case, living with the fear of contracting the virus. Again, while being mindful of the very significant treatment advances in recent years, Moore's (2004: p.xxvi) assessment of '*the bitterness of living constantly with death*' when describing the experience for many gay men living with the shadow of HIV was evidenced in the experiential accounts. That is, all were acutely aware of the potential challenges associated with the virus but especially so for those living with a positive diagnosis. For they described a stark and intense engagement with their

own mortality and so a profound crisis of being. This confrontation with finitude, together with the aforementioned issues with sexuality, are especially important aspects emerging from the findings from the perspective of gauging the effectiveness and relevance of existential therapy in this particular setting.

As shown in Chapter 2, an existential understanding of the human predicament considers living with both the certainty and anxiety of death to be inevitable corollaries of self-consciousness (Kierkegaard, 1844; Heidegger, 1962; Yalom, 1980). It is worth remembering that death in existential terms does not necessarily or exclusively mean the physical demise. It applies to any state of non-being that involves not actively and intentionally engaging with life (Heidegger, 1962; Deurzen, 2002). The participants, for example, conveyed instances of what can be considered to be forms of social death by describing events such as the ending of important relationships, of professional discrimination or compromised financial status. In whatever way it presents itself, the fundamental point is that we typically bury the associated raw ontological anxiety '*under layers of such defensive operations as displacement, sublimation, and conversion*' (Yalom, 1980: p.44). However, and crucially, sometimes major life events will bring it back to the surface and so we are forced to confront it. This was so for the participants who had been essentially compelled to face their vulnerability and ultimate isolation. From this same perspective, the presenting descriptions of anxiety, depression, poor self-esteem, and a pervading sense of loneliness were therefore ontic manifestations of ontological despair.

How an existential practitioner might formulate and think about the ways in which these presenting issues are impacting the experience of living can be shown by mapping them onto the four existential dimensions, as defined by Binswanger (1946) and Deurzen-Smith (1984; 1988) and evaluated earlier in section *2.2.2*. For example, an exploration of the intimate relating with self and others (in *Eigenwelt*, the private world) would be key to understanding the participants' fundamental unease. Equally so, in the social dimension (*Mitwelt*), the tension from living within the polarities of, for example; conformity and rebellion, belonging and isolation, acceptance and rejection could be contemplated. Their health concerns are

clearly located in the physical world (*Umwelt*); and finally, in the spiritual (*Uberwelt*) dimension their values, beliefs and sense of meaning seemed confused or inhibited by a pervading sense of worthlessness. From such a mapping process, we can see how the practitioner can develop a conceptual framework that both enables and ensures a holistic exploration of the lived experience; a fundamental intention of both ET and CoP.

Of course evaluating the suitability of the existential approach for addressing these particular presenting issues also requires appraising what the participants wanted to achieve from the therapy. All expressed wanting to establish meaningful and affirming relationships, an aspect of life that was currently largely absent. As part of this and perhaps most of all, they wanted to develop a more positive and accepting relationship with self. A crucial part of this process, and which the participants made unequivocally clear, was the need for the therapy itself to be a meaningful relational experience; something which is of course reflective of a central tenet of our discipline (e.g. Carroll & Tholstrup, 2001; McGinley, 2006). The participants undoubtedly wanted change and a new way of engaging with the world, but first they needed their current way of being to be acknowledged and respected. This would be experienced through a sense of being both understood and accepted by their therapist.

We have seen how a defining feature of existential practice is a phenomenological exploration, characterised by a genuine openness to the client's current way of being (Spinelli, 2005). The reason this is important is because to go beyond this in the earlier stages of therapy risks entrenching the client in their predicament. That is, adopting any sort of prescriptive stance would '*serve only to maintain the client's underlying currently lived way of being towards self and others*' (Spinelli, 2005: p.150). This is an especially important aspect to emphasise when considering the suitability of the existential approach within a time-limited setting. The accepting the client as they are must be neither rushed nor ignored for it forms an intrinsic aspect of the existential therapeutic process and is pivotal to a therapeutic journey towards developing a new relationship with self.

On the face of it then, the counselling fundamentals of empathy, congruence, and acceptance (Rogers, 1951) were at the core of what the participants wanted as they began their therapy.

Certainly their level of vulnerability and sense of isolation demanded a welcoming and empathic experience since that would be most conducive to engendering a committed engagement to the therapeutic process. However, from an existential practice perspective, and as outlined in Chapter 2, Deurzen (2002) warned against an approach that conveys '*total acceptance and empathy*' for the client since doing so risks acknowledging just one of the polarities in which they exist; and so constituting a '*false caring*' situation (Sartre, [1943] 1956). That is, ignoring important (perhaps less favourable) aspects of the client's way of being is ultimately a disservice to someone trying to source a new, more meaningful way of relating. Therefore, from the existential perspective, an ultimately more rewarding experience for the client is one in which the practitioner is as expressly interested in the aspects of being that may hinder the depth of relating and acceptance that they so crave. Such an approach clearly requires genuine curiosity, candour and courage in the therapy. I suggest this is more about a matter of timing and judgement. To challenge and contemplate all aspects of being (the favourable and the less so) of course should be the intention of the existential therapist for it is here the potential for a transformational experience resides. However, and as shown with one of my participants in particular (Jawaad), such candour and challenging can only be successfully done once a sufficiently trusting and mutually respectful relationship has been forged. Otherwise a sense of being misunderstood or even persecuted risks quelling any beneficial effect.

For the participants, therefore, this was first and foremost about the respectful acceptance that Spinelli (2005: p.151) referred to when describing psychotherapy as '*the attempt to 'stay with', 'stand beside', or 'attend to another'*"; while at all times maintaining an inquisitive and explorative attitude. It is also, as Levinas (1969: p.47) argued, about '*welcoming the Other*' in all their uniqueness with a '*non-allergic reaction with alterity*'. Doing so demands a deep willingness in the therapist to meet the Other in such a way that is free from any agenda to quantify, classify or change; while also respectfully challenging wherever appropriate. As Cooper (2009) argued, such a way of being with clients is in fact an ethical imperative for counselling psychologists. This is what the participants both wanted and I suggest needed and

so from this analysis, the existential-phenomenological approach was *theoretically* aligned to both engaging with their presenting issues and addressing their stated objectives.

The following section, which focuses upon the participants' actual experience of the existential therapy, shows how this was achieved in practice.

5.1.2 Sessions were a means for understanding and growth

A strong commonality amongst participants was that their therapy was experienced as being first and foremost an exploration of their worldview; their current way of being both in the world and in relation with others. Sessions were characterised as a process of understanding their unique lived experience and contemplating what a life more attuned to their values might look like. A meaning-making endeavour is of course at the core of the existential approach (Deurzen, 2002; Spinelli, 2005) and such a journey of discovery for people who feel that they are somehow at odds with the majority - that their 'difference' is unacceptable – holds much potential. This was substantially supported by the findings. By making explicit their difficulties and struggles, understanding their own engagement within the multiple contextual constraints in which they live, shaped and focussed the exploration for the participants around how to align living to be more at one with their ideals and aspirations.

To this end, the sessions were experienced as conversational, investigative and clarificatory in nature; providing the opportunity to understand their personal narrative and the meaning which they derive from it. This included an attending to the embodied experience; so naming and engaging with the felt emotions that Merleau-Ponty ([1945] 1962) deemed so fundamental to our understanding of consciousness and self-awareness. Thus, in becoming mindful of their experienced emotions the participants were afforded the opportunity to understand and formulate the intrinsic message being relayed. There was little suggestion of a solution-finding or prescriptive approach, and instead the sessions were principally experienced as being first about describing the problem and their position to it - thereby confirming that the phenomenological method of inquiry (Husserl, 1967) was central to the process.

The deconstructing and reframing of narrative through a co-created dialogue also evidenced a hermeneutic phenomenological exploration (e.g. Gadamer, [1975], 1996) as being a core aspect of the participants' therapeutic process. In her explanation of what such an existential meaning-making process can offer, Deurzen (2002: p.88) captures well the fundamental worth derived from making sense of their crisis in this way: '*When it becomes obvious that certain ideals and values are important to a person...Having to overcome public opinion, physical obstacles or character weaknesses can suddenly seem like minor challenges against the background of the worthwhile of fulfilling one's aspirations'*. While perhaps not being reduced to 'minor challenges' for my participants, by understanding the problems contextually, the perception of them had changed from seeming insurmountable to a sense that they were at least bearable and manageable. This is evidence of the enabling role that is a primary intention of existential therapy; empowering the client to make their own decisions about what changes need to be made.

From all participants there was a palpable sense of them discovering a substantively more vitalised and less disaffected way of living their lives, as well as a general sense of pragmatic optimism for the future. This was evident both in the interviews immediately after the therapy and in the subsequent follow-ups some twelve weeks later. Their meaning-making journeys had taken them from a state of crisis and low self-worth towards a more affirmative, confident and accepting relationship with themselves. The participants had achieved this by effectively recalibrating their engagement with the adversity that had entered their lives and so enabling more energised and purposeful living. So the therapy was not about a hasty retreat from the distress but rather constituted a sustained and focussed attending to the ontic manifestations of their ontological anxiety and relationship with the world and others (Kierkegaard, [1844], 1944; May, 1977, Tillich, 2000). The participants uncovered the makings of a well-lived life - utilising the ontological anxiety as a conduit for more purposeful living. The findings are, therefore, representative of some of the principle outcome objectives at the heart of the existential approach, as again Deurzen (2002: p.35) explained: *'…the task (in therapy) is not to suppress, disguise or deny anxiety, but to understand its meaning and gain strength to live with it constructively*'.

Such a process of becoming and learning from their unique challenges and distress required understanding the source and most importantly hearing the message. One participant (Michael) encapsulated the potential of this when he movingly spoke of how his HIV-positive diagnosis and related life-threatening illness had been his '*saving grace*'. A powerful paradox showing how being starkly confronted with death had served to rescue him from self-annihilation. As has been discussed, the revealing and clarifying of meaning implicit in such paradoxes of living as demonstrated here is at the heart of existential philosophy and practice (e.g. Deurzen, 2002). The more that existential therapists can facilitate and encourage clients to source the necessary courage to embrace this fundamental of existence, the more opportunity there is for purposeful living: as Kierkegaard ([1844] 1944: p.139) told us, '*the greater the anxiety, the greater the man*'. And so while it is '*the price we pay for freedom*' (Cohn, 1997: p. 71), it was also for these participants a wake-up call - through this they found meaning in place of a sense of futility, realising possibilities and the actualising of potential.

In summary, the therapy was not primarily focussed upon symptom alleviation, although this was undoubtedly a substantive effect. It was instead about harnessing lessons from their emotional pain and assuming responsibility for the choices and changes that they alone could make; all within the context of a more compassionate and accepting relationship with self. This was the key objective for all participants and through ETLT this process had at least begun. Therefore, from the perspective of suitability of the orientation to addressing the presenting issues and objectives of this particular client group, the findings suggest that it does, in a manner that is empowering, non-pathologising and affirming.

I turn now to the aspect that perhaps more than any other permeated and defined the therapeutic process for the participants – the therapeutic relationship.

5.2 Relational factors and how they shaped outcome

As has been shown in Chapter 2, much of the seminal literature identifies the establishment of an early therapeutic alliance as key to positive outcomes (e.g. Asay & Lambert, 1999; Lambert, 1992; Norcross, 2002; Wampold, 2001). With the central importance of the

relationship permeating all experiential accounts, this position has been unequivocally endorsed by the current research findings. As stated at the outset, therefore, a main research aim for this project was to explore how and in what ways it influenced the participants therapy experience.

Based upon the analysis of interview data, I have identified three main aspects that I consider to be worthy of particular attention and which as such I will address in turn below. These are:

1. The participants reported that when starting the therapy process, perceived differences with their therapist could inhibit the all-important development of trust. This was specifically shown in subordinate theme 1.2 '*Obstacles to trust*' and will be explored below in section 5.2.1.

2. There was a clearly expressed need and desire across all accounts for an overtly relational experience with the therapist irrespective of therapeutic orientation. This was principally addressed in subordinate theme 1.3 '*Substance over style*' as well as being evident throughout accounts and will be discussed below in 5.2.2.

3. The participants described *how* the relationship affected both the therapeutic process and subsequent outcome. Again, apparent throughout the experiential accounts but specifically shown in subordinate theme 2.2 '*How the relational alliance is the conduit for change*' and discussed in terms of existing literature and implications in 5.2.3 below.

First, I turn to a consideration of the identified obstacles to a therapeutic alliance.

5.2.1 Profile differences and their impact on the development of trust

As identified in exploring the presenting issues in section 5.1 above, the participants' unease and anxiety around being with others was particularly influenced by how they experienced their own way of being in the world sexually. They approached the therapy with a profound sense of isolation, shame, persecution and a pervasive fear of rejection and judgment. It is from this context that feeling safe and able to trust the therapist enough to disclose that which has been experienced as being so unacceptable were identified as pivotal to establishing a working therapeutic alliance. The collective view was that this would be best facilitated by experiencing a sense of commonality, solidarity and a fundamentally affirming attitude from

the therapist. Specific factors that were described as being potential obstacles to this were in differences of culture, gender, and sexuality.

One participant (Jawaad) reported significant concerns around language; fearing his therapist, whose first language was not English, was sometimes missing the nuances of his vernacular. An understandable anxiety particularly given his eagerness and need to be heard and understood. This was, however, I think reflective of a wider anxiety regarding what the participant perceived to be very different cultural backgrounds and an associated assumption that his therapist simply could not relate to his lived experience. Certainly, Newnes (1996) argued that therapy can never be '*culture-neutral*' since our cultural context inevitably influences our worldview – a position with which a hermeneutic phenomenological vantage point surely concurs. Equally, Clarkson (1997) argued that trans-cultural factors are of fundamental importance since they can negatively impact the therapy relationship development, and so should not be ignored when allocating referrals. Undoubtedly for Jawaad in the current research, this proved to be a substantive issue and indeed an obstacle to relationship development, lending support to Clarkson's argument that trans-cultural referrals require caution and careful consideration. This is not to suggest that they should be unequivocally avoided, but that the potential for this being an impediment to trust for some clients should be gauged and included as part of the assessment process.

In terms of gender, this was essentially enmeshed with issues of sexuality. Basically, the primary view expressed was that women are more likely to stereotype and judge gay male sexual behaviours than men. As such, gay male clients will typically find it more difficult to disclose to a female therapist and so the therapeutic process will be inhibited. Incidentally these findings run counter to research on the effect of gender by Bernstein and Lecomte (1982) and Maslin and Davis (1975), both of which showed that male therapists were significantly more inclined to stereotyping than their female counterparts. Further, in their study of therapist gender and the impact on attitudes towards clients, Artkoski and Saarnio (2013: p.6) found that female therapists '*had the most positive attitudes towards the homosexual male client*' and allude to the Kelley (2001) meta-analysis of attitudes across

twenty-nine nations that showed women typically have more positive and accepting attitudes towards homosexuality. However, while this certainly was a clear and strongly expressed opinion for some of the participants, it should be considered within the context of their reported outcome and overall appraisal of the value they attached to the therapy. Specifically, those who had a female therapist did not ultimately conclude that this had prevented them from achieving their therapy objectives. Nonetheless, the general view that matching male clients with male therapists was favourable because gender difference *may* slow the essential development of trust, was for some participants firmly held and so this should not be ignored.

Taken together, these identified concerns with culture, language and gender were essentially manifestations of the underlying difficulties with being in the world sexually. That is, fear of judgement and rejection was driving the call for sameness. Certainly there was a view from the participants that their process could well have been accelerated by 'profile matching' particularly in terms of sexuality, something that Davies (1996) argued to be so important for LGB clients. As we have seen, Davies also argued that an explicitly gay affirmative approach was essential for this client group; one key intention being that the client's sexual desires are validated and normalized (Malyon, 1982; Shernoff, 2006). The findings support the view that feeling understood and accepted by the therapist with regards their sexuality was of fundamental importance and where it was experienced, it was welcomed.

However, the idea of adopting and conveying such a positive stance highlights the dilemma for existential practice alluded to in Chapter 2. Namely, that the therapist assuming a gay affirmative attitude can seem fundamentally at odds with the existential-phenomenological approach since to adopt *any* stance other than openness and genuine curiosity is incompatible with epoché (Du Plock, 1997). Therefore, it could be argued that where a gay affirmative attitude was experienced by the participants, it was indicative of the therapist integrating a more person-centred/positive regard to the work. That said, if we return to a key characteristic of existential phenomenological practice; accepting the other (Spinelli, 2005), indeed welcoming the '*otherness of the Other*' (Levinas, 1969), then surely this is entirely compatible with what the participants hoped for and valued. In other words, the therapist being with the

client in all their 'otherness' (including their way of being sexually) would seem both attuned to what the participants wanted and is, I would argue, also reflective of a key tenet of existential practice.

It is again worth emphasising that all participants in the current research ultimately reported substantive positive outcomes which were concordant with their objectives. This could be despite or even *because* of the profile differences identified above. Indeed the fact that their therapist was in some ways representative of that which they felt most alienated from – the 'conforming majority' – may well have afforded a profoundly healing experience; assuming of course that an accepting attitude was conveyed by their therapist. Further, such differences can be used as leverage by inviting the client to observe and contemplate their own prejudices. In this way, client-therapist profile differences enable the client to inspect their fears and assumptions about themselves and others (as an opportunity to unearth internalised homophobia, for instance). The benefit of a positive experience by being with difference may well be of considerable worth and certainly the outcome appraisals from the participants do not discount this.

Therefore, I do not conclude from these findings that we should necessarily consider client/therapist profile-matching to be the preferred referral option. However, it *is* of fundamental importance that as therapists we recognise that people whose lived experience has included significant discrimination may well have developed well-honed defences in response to it. One associated effect of this could be the client dissociating or disengaging when perceived differences with their therapist invoke their fear of judgement. Hence where a clear (real or potential) difference exists - be it gender, sexuality, cultural and/or language - the therapist has a responsibility to explore with the client what it is like being with such differences. If the client does have any concerns, by the therapist conveying cognisance of the potential influence of such barriers, he/she will be re-assured and so facilitating the development of trust – in both the therapist and the therapeutic process. Further, from such an exploration, fundamental anxieties indicative of their way of being in the world may well be revealed.

5.2.2 The need for a relational therapist

Overall, the message communicated from the participants was that the orientation of their therapist was of much less concern when compared to their hopes for a relational experience. This is consistent with the seminal process research addressing this specific question (e.g. Asay & Lambert, 1999; Bohart, 2005; Lambert, 1992; Norcross, 2002; Wampold, 2001). That is, people encountering problems with living and seeking resolution or alleviation through therapy are generally less inclined to be preoccupied with the specific approach than they are their need for the therapist to understand and relate to them and their predicament. This concern amongst participants around the relational aspects by far also outweighed any significance being afforded to specific strategies; both supporting the illuminating research by Timulak (2008) and incidentally contrary to a common assumption amongst practitioners that clients will attribute change to particular techniques employed. Indeed there was little evidence of any desire for an explicitly structured or technique-laden approach - something which, as shown in Chapter 2, the existential approach is naturally sceptical of (Cooper, 2003; Deurzen, 2005).

Therefore, the challenge posed, for example, by Sachse (2003) when calling for a favouring of strategies and techniques over a relationally-focussed approach would be directly contrary to the self-assessed needs of these participants. They were instead unanimously clear on their need for an overtly relational experience. Of course we cannot make the assumption from this of a uniform attitude of all clients in terms of this or indeed any aspect of therapy. As Norcross (2002) and Beutler et al. (2004) have argued, the level to which the relationship is of importance will vary depending on the particular client group and presenting issues; and not discounting individual differences. What we can say, however, is that the participants in this particular setting unequivocally deemed an engaged relational therapist to be pivotal to their process and, crucially, essential to a successful therapy outcome.

As explored in Chapter 2, there is already extensive research (e.g. Norcross, 2002; Cooper, 2009) positioning the client-practitioner relationship as being a key determinant of positive outcome and this is strongly supported by the current research findings. However, given the

breadth of existing research on this, it is perhaps not in itself especially informative or revelatory to be reporting similar conclusions here. Mindful of this, a key aspect of my analysis of findings was to specifically examine *how* and *in what ways* - both positive and negative - the relationship proved to be of such significance to the overall process for the participants. While such aspects emerged across the findings, they were in particular captured in subordinate theme 2.2. As such this constitutes the main focus of the following section which examines the specific elements contributing to a successful collaboration.

5.2.3 The components of an effective therapeutic relationship

The most important factors identified by the participants as contributing to a positive therapeutic relationship were:

- an engaged and interactive therapist, conveyed in both their dialogue and physical presence (the being-with-other)
- the therapist communicating a normalizing attitude, while not trivialising or discounting the uniqueness of their situation
- an associated sense of commonality and sameness; expressed, for example, by a degree of therapist self-disclosure and humour
- the dialogue being experienced as collaborative and co-created

Collectively, these conveyed to the participants a sense of acknowledgement - widely accepted as central to a relational experience (e.g. Schmid, 2002); also inclusion, acceptance and a general impression of meaningful interaction or '*relational depth'* (Mearns, 1997). Taken together, they are also largely reflective of Clark et al.'s (2004) review of what clients find most helpful in therapy. Some can be considered common to all orientations such as the importance of a sense of acceptance and acknowledgement. However, others can be viewed as being representative of the existential approach in particular, and these are:

> ***Relational therapist and the being-with-other***: at the core of the existential approach is an explicitly relational understanding of how we are in the world (Heidegger, 1962) and a core aspect of this in therapeutic practice is for the therapist to authentically bring them self to the encounter (Cohn, 1997; McGinley, 2006; Spinelli, 2005). Revealed in the participants' accounts is how the sense of isolation and relational

anxiety which they were experiencing were to some extent alleviated simply by being with a present, engaged and accepting other. Specifically, in the immediacy of being with their therapist they experienced their way of being with others and this in itself was instrumental in moving the participants from confusion and crisis towards a sense of calm and hope. Where this occurred, the inherent potential of Spinelli's (2005: p.149) '*we-focused*' inquiry was supported since, as he argued; '*the self-same inter-relational issues that clients express as being deeply problematic within their wider world relations'* were experienced in the here and now of the therapy.

Perhaps most informative, when one participant, Jawaad, experienced his therapist as overtly non-relational and resolutely boundaried, he was left with a sense of the therapy as being a wasted opportunity. He recalled, for example, how she described to him the resolute delineation she maintains between her personal and professional opinions. I would concur with Jawaad in so far as there was a rich seam for exploration and learning here since his way of being in relation with others was being essentially experienced with his therapist, reflected in his plea for understanding and interaction. The problem, therefore, was that his experience of their relationship was not addressed and nor, it would seem, was there an attempt to understand why this felt so important for Jawaad.

This may well have been because of an unease for the therapist with regards embracing the intimacy of the therapeutic relationship and so retreating to the safety of the 'objective professional'. As therapists, therefore, including those subscribing to an explicitly relational orientation such as existential-phenomenological, we must be mindful of our own processes and worldview. The therapeutic relationship is indeed an intimate one – it is entirely created for the purpose of the client laying bare their most personal thoughts, life experiences and vulnerabilities. However, the need for candour and courage does not reside solely with the client. For if we as therapists subscribe to the relational attitude to working that our discipline demands we do, this requires from us an openness to meeting the client in a spirit of honesty and genuine eagerness to understand. In doing so, we should be prepared to bring ourselves to the

encounter, first and foremost as one person being with another, resisting any expert persona and the associated remoteness and separateness this can afford. This more than any of other experiential account confirmed the importance of personal therapy for practitioners as well as of course robust supervision.

Conveying a normalizing attitude to client: as outlined in Chapter 2, a key characteristic of the existential approach is the non-pathologising attitude to problems with living. Emotional unease and distress are not seen as necessarily manifestations of a psychological disorder or illness but rather as being representative of difficulties with being in the world and which must be understood and addressed mindful of the contextual and relational matrix in which we all exist (e.g. Deurzen & Arnold-Baker, 2005; Milton, 2010). Where such a normalizing attitude to unease was experienced by the participants, they reported it in itself having a reassuring and healing effect. Again, mindful of their context and perception of embodying unacceptable difference, this emerged as a fundamentally important contributing factor to the development of a trusting therapeutic relationship. Existential practitioners can therefore be encouraged by this endorsement of the unique potential inherent in such a key underpinning of the approach.

However, there also emerged an important message of caution from what appeared to be a conflict between remaining 'true' to the orientation in terms of not pathologising and a resultant losing sight of client subjectivity. In the case of Oliver, he recalled both in his assessment and also once actually referred that both (existential) therapists essentially dismissed his concern that he was a sex addict. Neither appeared to engage in any significant exploration of what this meant for Oliver, far less acknowledging that this was an important objective for the therapy for him. There may have been worth for the client in his label of addiction, but rather than this being explored it seemed to be too readily discounted.

Contemplating the client's experience through the prism of theories, but also questioning the relevance and worth of these in terms of facilitating *their* objectives,

is crucial and fundamental to existential counselling psychology. As Manafi (2010: p.27) argued, such questioning '*is both a professional responsibility and an ethical one since counselling psychology is not just an academic discipline but a therapeutic stance towards psychological difficulties*'. This should extend to the existential attitude towards theories, labels and diagnoses; our general reluctance to adopt them cannot cloud our engagement with the client's experience and embrace of them.

While of course it is the therapist's role to challenge and uncover outdated or unhelpful perspectives, we must be careful not to forget the fundamental acknowledgement of subjectivity that characterises the profession. The existential therapist whose intention may well be to alleviate anxiety around a diagnostic label by minimising its relevance, risks assuming the position of dogmatically subscribing to 'non-dogmatic' therapy. In other words, losing sight of the client's worldview and so the very essence of what existentialism is about. We may not pathologise but if the client does then we should work with that – exploring their truth, their reality.

***Therapy as a collaborative exercise*:** where the participants experienced a supportive and egalitarian environment, they felt empowered and able to confront their distress. These reflections are indicative of a defining feature of the existential-phenomenological approach which positions the therapeutic relationship as fundamentally equal in nature. As Spinelli (2005: p.151) reminded us, existential practitioners reject the notion of therapist as a '*superior, objective instructor*'. Rather, the intention is to empower the client by restoring or instilling a sense of agency and responsibility for their own lives. As such a stance of expert who knows the 'right' way forward, risks adopting a manipulative stance, albeit a benevolent one (Spinelli, 2005). Perhaps most importantly, according to the current research findings, such an attitude will be evident from the earliest stages and could significantly impact how - even if - the client engages in the therapy.

In appraising each of these aspects of the therapeutic experience, three of Bohart's (2005) *five common factors model* are supported: the relationship (*being-with-other*), the role of the

therapist's personality (conveyed through self-disclosure and humour, for example), and the client as self-healer (*therapy as collaborative exercise*). The two other factors identified by Bohart: the therapist ability to instil hope and optimism - while not explicitly reported by the participants it is implied in their outcome reflections; and the therapist's ability to offer a '*healing explanation*' could be argued to be present within the normalizing attitude and dialogue.

To sum-up, an overtly relational therapist and a strong therapeutic alliance were experienced and identified as being of the greatest therapeutic value above all else. Conversely, where the therapist was experienced as non-relational, where professional boundaries were staunchly asserted, a message of remoteness, detachment and difference was conveyed. Such an attitude risked consolidating or exacerbating the presenting issues of low self-worth, isolation and fear of rejection.

In the following section, how the findings support the view that the specifically time-limited setting itself creates the environment for an energised and focussed exploration will be examined. The principle argument being that the frame itself affords much therapeutic potential and can act as a facilitator of positive outcome.

5.3 The influence of the time-limited frame

A central intention of the current research has been to understand the impact, if any, of the time-limited setting in which the existential therapy was provided. Specifically, to establish how, if at all, the time limitation in itself influenced outcome and if indeed the existential approach is viable within such a constraint. Therefore, this third area of focus is upon what I have identified as constituting the structural aspects of the therapy provided at HCS. To this end, I evaluate below the twelve-week setting with a particular focus upon the ways in which it was experienced to shape both process and outcome. Three subordinate themes in the findings specifically addressed this aspect of the research: '*The opportunity of a time-limited setting*' and which will be discussed in 5.3.1 below; '*The value in taking stock*' which forms the

basis of 5.3.2 and finally '*An ending...and a beginning*' is discussed in section 5.3.3. I discuss the key points raised in each of these in relation to the existing literature, and again, with the purpose of explicating the contribution to our knowledge and practice.

5.3.1 The unique potential of a time-limited setting

The participants all received twelve therapy sessions on a weekly basis. However also, by way of the two interviews they attended for this research project they received effectively two subsequent 'follow-up' review sessions. While I acknowledge of course that the explicit purpose of these interviews was research - and was at no time positioned as forming part of their therapy - the participants nonetheless experienced them as forming an integral part of their therapeutic process (an important outcome in itself and which will be explored further below). The participants also departed the therapy process with the knowledge that should they wish to, they could apply for a new contract after an elapsed twelve week period. Collectively, these components mirror the time-limited model suggested by Strasser and Strasser (1997) and so the findings of this research can reasonably be considered to constitute first-hand accounts of the Strassers' model in practice.

When considering specifically the time-limited aspect of this research, it is also important to acknowledge that in relative terms the twelve sessions offered at HCS are at the upper end of what is typically deemed to be 'time-limited'. Most models refer to around six sessions as being typical (e.g. see De Shazer, 1985; McConnell, 2005; Bor et al., 2004). Further, in terms of session uptake by clients, Welfel and Danzinger (2006) cite studies that indicate the average number of sessions actually attended to be less than four, while the American Journal of Psychiatry (2003) reported a mean number of contract duration based upon client attendance as being between five and eight sessions. Within this context, therefore, the twelve session contract provided at HCS is substantive. Perhaps reflective of this, no participant in the current research reported the twelve sessions that they had to be insufficient for addressing their needs and objectives.

In terms of how the frame was experienced, the key defining characteristics described by the participants are aligned with much of the seminal literature. These were: *a sense of urgency*

to the work - on account of there being a definitive end-point, an associated experience of *focussed explorations*; and crucially, the *early establishment of a therapeutic alliance* as a prerequisite to both. Notably, a sense of focus to the dialogue did not necessarily mean assiduously attending to a single issue throughout the contract, as several have argued time-limited therapy should (e.g. Weismann et al., 2007). Instead the sessions typically included a wider exploration of the participants' contextual life, how they see themselves and engage with the world. The focus referred to was more in terms of a sustained attention to that being explored; assiduously addressing specific issues but from a holistic perspective. This approach, I would argue, was especially appropriate with a client group presenting with such a 'non-specific' issue of what amounted to an unease of being in the world.

Crucially, according to the experiential accounts such a wide-ranging enquiry was achieved to an appropriate degree within the twelve-week timeframe. This is an important point, and as stated above, runs counter to much of the mainstream thought around time-limited approaches. Although again, it is equally important to be mindful of the relatively high number of sessions received within a time-limited contract. Clearly, for instance, we cannot claim that the depth of exploration and focus described in the current findings could be readily assumed to be equally applicable to say a six session existential brief therapy model. Nonetheless, each participant began the therapy with an acute and profound sense of isolation and unease of being, and so typically a prolonged, open-ended exploration might be considered by practitioners to be the most suitable approach in such circumstances. Each left, however, with a clear sense that a substantive, relevant and sufficient-for-now piece of work had been done, combined with a corresponding amount of satisfactory progress made.

Perhaps above all though, in terms of defining characteristics of the time-limited setting, it was the certainty of the ending that was identified as the most influential distinguishing factor. Awareness of the time constraint served as the catalyst for the energised and focused experiences described above, supporting the argument that by simply knowing there is an end date imbues a unique potential in '*time-defined*' frames (Strasser and Strasser, 1997). By making explicit the number of sessions (overall and remaining) to the client, the therapists

instilled a pace to the work. Key commentators (e.g. Mann, 1973; Hoyt, 1995) have argued that this is inevitable when the temporariness of the therapy is stated. Indeed, they argue, not only does it set the pace, it also provokes a wider contemplation with temporality and finitude. Therefore, while Bor et al (2004) argue that it is the early establishment of the therapeutic relationship that is pivotal, the current findings suggest that both factors are significant catalysts; and that they are directly associated. That is, through an established relationship (which needs to occur sooner rather than later in a time-limited setting), a meaningful engagement with temporality and ending can be facilitated. Such an engagement would seem to be particularly pertinent, profound and perhaps even necessary for clients presenting with issues of isolation and fear of rejection as these participants did.

The leverage afforded by a strong and trusting working alliance means that the therapist enquiring about how the client feels about ending is well-placed to enter an authentic, relational dialogue about the fears, anxieties, and vulnerabilities that the ending evokes. This was the experience certainly for two of the participants - John and Michael – who described how by attending to their felt anxiety in relation to the temporariness of the therapy, the underlying ontological anxiety and fear of isolation was revealed to them. From this they recognised the value of living in the here and now, appreciating and enjoying a relationship while it exists, but also – crucially - that the inevitable sadness of it ending does not negate its' worth. These are sound examples of the potential in a time-limited contract when coupled with a strong therapeutic relationship.

All participants had an acute awareness of the fragility of life, and the despair associated with confronting loss and death. Therefore, in terms of the potential of the time-limited setting, by utilising and making explicit the time constraint, a unique opportunity for an existential enquiry and their relationship to the givens of existence (including choice, responsibility, courage and freedom) was facilitated. By engaging with the inevitability of the ending provided the participants with an opportunity of experiencing a new way of being with others, including communicating needs and wants. As Strasser & Strasser (1997: p.13) argued, therefore, '*time becomes a tool in itself when employing a time-limited therapy model*'.

However, there were also in my view some missed opportunities from the therapists when an explicit link with the therapy limitation and temporality did not happen. For example, when Michael reflected on being in a rush to make changes in therapy and a general loathing of *'wasting time',* this offered the therapist an opening to exploring his relationship with temporality. It was instead in the research interviews where such links were made perhaps highlighting the inherent potential of reviews, and which I discuss further below.

5.3.2 The therapeutic potential of external reviews

The interviews conducted for this research offered the participants the time and space to reflect upon their recent therapy experience and this itself was identified by them as forming a beneficial and pivotal component of their therapeutic process. This was essentially because it conveyed the impression of a tailored and more comprehensive service; and by maintaining a specific interest in their outcome objectives this in turn communicated a genuine and sustained interest in the client's wellbeing beyond the therapy. Basically a sense of professional 'after-care' was experienced and welcomed. This was particularly important since a sense of dissatisfaction with the nature of the ending was evident for some of the participants; it had seemed to be somewhat abrupt – an impression they reported would have persisted without these research 'reviews'.

This reported sense of dissatisfaction with the ending specifically, of course may well have been indicative of lingering and persistent emotions around the loss of the therapy generally; and reflective of the *'fear, anger, sadness and the recollection of previous losses and rejections*' that Strasser and Strasser (1997: p.15) referred. However, by taking stock in the interviews - including concerns about the ending and how it was addressed - evidently unlocked potential for a meaningful assessment of their felt responses and so presented a significant learning opportunity. Therefore, I suggest it to be highly desirable for practitioners to facilitate a post-therapy review where possible and practicable since it provides an additional opportunity for reflection, making sense of the therapeutic journey; thereby enhancing and consolidating therapy gains.

This is clearly not in itself a new or original suggestion; post-therapy reviews have widely been considered to be useful for both time-limited and longer term approaches (although perhaps not so widely implemented). From an existential perspective, both Bugental (1995) and Strasser & Strasser (1997) emphasised their importance, with the latter recommending two such sessions subsequent to the contract ending. However, the key variance in the current research was that I had not been their therapist – from an external position, I was inviting an appraisal of their therapy and indeed the therapist. Based upon the findings, it is this very distinction that holds particular potential since the reviewer being external appeared to facilitate a more candid and comprehensive assessment. Mindful of the presenting context of this client group, candour with their therapist in terms of a therapy review may well have felt simply too challenging a prospect.

5.3.3 Therapy as the initiator of change

In reporting a sense of their journey being in some important ways initiated by the therapy as they departed it, rather than as a completed process, the participants again reflected the research that identifies this as a key characteristic of time-limited therapies (e.g. Bugental, 1995; Bor et al, 2004; De Shazer, 1985; Strasser and Strasser, 1997). All expressed an acknowledgement of the inevitable limitations of what could be achieved in the allocated time but at the same time leaving their process feeling empowered; equipped with at least the foundations of a new, more accepting and respectful relationship with self. While De Shazer's brief solution-focused therapy aims to provide clients with a '*skeleton key*' to utilise after the therapy (a term which incidentally evokes for me a 'one size fits all' model), the twelve sessions of existential therapy offered these participants rather more than 'bare bones' on which to build towards solutions.

Substantive progress was achieved in this timeframe for the participants and this included a newly emerging accepting relationship with self as well as clarity around what a well-lived life would look like and how that could be achieved. The findings, therefore, represent an unequivocal endorsement of existential time-limited therapy since the time constraint served

to engender self-reliance and self-confidence in the participants to continue their process beyond the therapy. Further, an explicitly existential approach, underpinned by the givens of responsibility, choice and freedom; and the idea that we are never complete, always becoming, seems to be especially congruent and comfortable as a viable orientation within a time-limited setting. In the following section I bring together the identified implications from the Analysis of Findings and evaluated above in terms of their clinical contribution for practitioners.

5.4 Research contribution and recommendations for practice

As well as being a key requirement of my doctoral training, at the core of this research has been the intention to offer a meaningful contribution to the knowledge-base of counselling psychology; and specifically to our understanding of time-limited existential therapy within that.

In the sections below, and for ease of cross-reference and where practicable, I present the clinical implications systematically in the order that they have been so far discussed.

5.4.1 Suitability of existential practice

Presenting issues and therapy objectives:

In terms of the specific presenting issues that emerged in this research, the findings strongly endorse the appropriateness of the overtly relational approach that characterises counselling psychology, and the existential orientation specifically. I evaluate below this central implication from the perspective of both theory and clinical practice.

To recap and as discussed in *5.1.1*: all participants presented with a profound un-ease with being which, I have argued, was directly associated with their experience of being sexual. This was principally manifested in a sense of isolation; social withdrawal; anxiety; and fear of persecution and rejection.

From a theoretical perspective the objectives were closely aligned to the defining characteristics of CoP, which as shown in Chapter 2, is a pluralistic profession underpinned by key existential-phenomenological ideas. These include: a fundamental acknowledgement of the subjective lived experience (the participants wanted *their* reality to be heard and understood); and our inherent relatedness in the world and with others (at the core of their distress was isolation and a yearning for acceptance and meaningful relating). All were unequivocal in the view that a key component for achieving this would be by experiencing an overtly relational and interactive dialogical approach. Indeed this was deemed essential to the process and again reflects a defining feature of both CoP and ET: a collaborative and egalitarian understanding of the therapeutic relationship. Therefore, what this group both wanted and needed were strongly attuned to what CoP and ET can offer.

In terms of how these objectives were achieved in practice, the sessions were characterised in large part by two central features of existential practice: the phenomenological reduction method of bracketing, description and clarification; and a hermeneutic dialogical exploration. In the immediacy of the therapeutic encounter, the clients experienced a crucial sense of acceptance of how they presently are, free from perceived judgment. From this position they felt enabled to engage in a meaning-making process to understand their lived experience and their role within it, and what they could change.

The findings therefore support the view that practitioners utilising these existential-phenomenological methods and engaging in a collaborative and relational dialogue, serve to embolden and empower clients. By encouraging a holistic exploration of their way of being, their core values and aspirations; and making explicit where there is dissonance, alternative life choices can be identified. Herein resides the potential for a new accepting and affirmative relationship with self. In doing so, two further core intentions of CoP practice: encouraging a focus towards wellbeing and the realizing of client potential, are addressed.

Further, and as '*encouraged*' in the BPS (2012) Professional Practice Board guidelines for working with sexual minority clients, based upon these experiential accounts I suggest it is in fact *necessary* for practitioners working in this domain to sufficiently familiarise themselves

with the wider issues and socio-political context for people living non-heterosexually. This includes common assumptions made, pejorative stereotypes and their associated impact. Perhaps above all, practitioners have a responsibility to acquaint themselves with how the profound shaming effect of social stigmatisation (realised and fear of) can impact mental health and wellbeing. Without practitioners equipping themselves with this knowledge, the client's experience of feeling understood - which the participants in this research identified as crucial – risks being significantly inhibited.

5.4.2 Therapeutic relationship factors

Therapist profile factors:

The participants sought above all else to experience their therapist as being able and willing to understand their problems with living. They wanted someone who could engage with their unease by first and foremost conveying a genuine interest and open-ness to their lived experience. As discussed, accepting the client as they are reflects a seminal feature of the existential-phenomenological approach (Spinelli, 2005). Equally, as Cooper (2009) argued, such an attitude of '*welcoming the Other*' is '*an ethical imperative*' for the counselling psychologist. Having feared and experienced rejection and persecution in their lives, feeling able to lay bare their vulnerabilities was a crucial prerequisite to any positive appraisal of outcome. In other words, establishing a sense of trust in the therapist was an essential foundation and determinant of all else that could follow.

As stated earlier, and in line with current BPS guidelines, a key aspect of this would include the practitioner ensuring that they are cognisant with the specific challenges sexual minorities face. Given the dynamic nature of this area, this may well require an element of continuing professional development to ensure practitioners remain abreast of the current socio-political situation and potential implications. Of course, engaging with and understanding the lived context of our clients is a defining characteristic and intention of CoP generally.

However, this is especially important for practitioners who do not identify as belonging to a similar sexual minority and so cannot expect to readily garner or convey a genuine

understanding of their client's lived experience unless they have duly familiarised them self with some of the key issues encountered. For example, very recently in the UK we have witnessed the introduction of equal civil marriage rights for same-sex couples which has been widely regarded as a very important step in social and cultural inclusion. However, practitioners should be mindful not to assume that such developments necessarily herald the demise of social stigmatisation and persecution. Indeed in some sections of society we have seen these intensify. For instance, the Stonewall commissioned *Gay British Crime Survey* in 2013 found that hate crimes continue to be a very present and serious problem in the UK, reporting that '*one in six lesbian, gay and bisexual people experienc(ed) a homophobic hate crime or incident over the last three years…suffering wide-ranging abuse, from physical assaults and threats of violence through to harassment, verbal insults and damage to their property*' (Guasp et al., 2013: p.4). This somewhat complicated current socio-political context, and the potential profound implications for clients need to be acknowledged and understood.

Some further specific ideas around how an early sense of trust and understanding can be achieved – as well as hindered - emerged as follows:

1. A sense of commonality with the therapist hastens the establishment of trust and so development of an early therapeutic alliance. Therefore, a gay male therapist might more readily engender a sense of solidarity and understanding to gay male clients

2. Related to the above, differences in gender, culture and language can be experienced as impediments to the development of trust. This is essentially because they can convey an impression that the therapist will be more inclined to stereotyping and making assumptions about a way of being that they have not personally experienced. So again, the responsibility for the practitioner to engage with the lived contexts of their client is crucial.

The central point to emphasise here in terms of therapist profile is that we must be conscious of such possible obstacles to the relationship formation; especially so with client groups in

which there is intensified anxiety around acceptance, difference and the fear of rejection. The reflexive practitioner should therefore be prepared to make explicit and explore with their client whenever such anxieties are apparent and influencing the therapeutic process. This is no more pertinent than in time-limited settings where, as has been shown, an early alliance is so strongly correlated with a successful outcome.

Therapist way of being:

As discussed thus far, the findings strongly supported the pivotal importance of an overtly engaged and relational attitude being conveyed by the practitioner. Where this was not experienced, the development of the therapeutic alliance was significantly hampered which in turn risked consolidating the client's general sense of isolation and unacceptability. Therefore, and *from the outset*, the therapist should work to deliberately convey an attitude of openness to difference. This will primarily be conveyed through an actively inquisitive, but always accepting and affirmative, dialogue.

It is important to emphasise that by affirmative, this is about the practitioner being mindful of their own language which, and as stated in the aforementioned BPS 2012 guidelines (2.3), '*could inadvertently be prejudiced, heterosexist or gender-biased*' and (perhaps explicitly) acknowledging the adverse challenges and effects of social stigmatisation.

Further important aspects of *how* the practitioner's way of being in the sessions impacted the process and the associated implications for clinical practice are as follows:

1. Without an established therapeutic alliance, substantive silences in early sessions can be experienced as punitive and so inhibit the clients' readiness to disclose. In the current research, they were not, as presumably intended, experienced as a space for contemplation nor of engendering a sense of responsibility or control to the client. Of course it is entirely possible that what is being revealed here in the immediacy of the therapy is the client's unease in relating – and so reflects a valuable learning potential that good CoP practice would work to address. Nonetheless, if we acknowledge the essential element of a trusting relationship, practitioners should be

cautious and mindful of the potency of silences, especially so in initial sessions.

This is but one example of how we as practitioners must remain alert to what is happening in the encounter and our role within it. It again reflects a principal characteristic of CoP and existential practice – a collaborative and egalitarian approach and attitude towards the therapeutic relationship. In practice this means regularly checking with the client how they are in the process; if they have any unease and how they are experiencing their therapist. This can again serve to empower the client, and in their responses there may reside rich seams for useful co-created dialogue.

2. As evident across this chapter, there resides much healing potential in the experience of acknowledgement and feeling understood - the *therapist as witness*. One particularly effective technique employed by one practitioner to convey this was the use of drawing to articulate her understanding of her client's dilemma. As well as conveying understanding, this also served to both clarify and focus the exploration, and so utilising such visual tools may be especially useful in time-limited settings.

3. The physical being with the therapist was in itself identified as a healing factor and so an important part of the therapeutic experience. This highlights an important aspect of *relatedness* for CoP and ET; that there is an inherent therapeutic potential in the holistic experiencing of the other. I suggest that this is particularly noteworthy and deserving of consideration given the increasing prevalence of telephone/online counselling now replacing face-to-face services. Given isolation was a common presenting issue of this particular group, I suggest that a face-to-face experience was therapeutically the most appropriate.

5.4.3 Time-limited frame perspective

The findings support the argument extended by Strasser and Strasser (1997) that there is a unique potential in ETLT from the perspective of how it can engage with concepts such as responsibility, choice, isolation, temporality and death. Exploring the paradoxes and tensions

that are an inherent part of our temporal existence – and which is a defining aspect of existential practice generally - is particularly effective and accessible in a therapy frame which manifestly reflects this given. By explicitly utilising the certainty of ending we can provoke a wider engagement with the client's own temporariness and in doing so, an opportunity for harnessing a sense of urgency to life can be presented.

In the current research, where the relationship was experienced as being slow to develop and the therapist as non-relational, outcome was assessed to be adversely affected. With one participant, there was a sense of substantial time being 'wasted' as he tried to elicit a more interactive style from his therapist. It is surely feasible that this could well have had an inhibiting effect on the extent of any therapy gains, if the client is preoccupied with establishing a sense of relatedness with their therapist; all the while their objectives remain unattended to. It could also, of course, constitute the makings of a very beneficial therapeutic journey for the client as they experienced and reflected upon their role and responses to being in-relation with another.

However, the structural constraints of a time-limited setting by definition require practitioners to be cognisant of what can be achieved in the limited number of sessions available. As such, where necessary, they should purposely adapt their personal style and interventions accordingly to reflect an actively relational, welcoming and accepting attitude. This is necessary from the very beginning in order to facilitate an early collaborative therapy alliance so that the focus can then be more readily set on the client's actual objectives.

This is fundamentally about practitioners recognising the necessity of instilling pace and energy to the sessions and overall contract. By acknowledging that this will more likely happen with the early development of trust combined with making explicit to the client the impending ending; together create the foundations for meaningful and effective work. It is also important for ETLT practitioners to remain mindful of what can realistically be achieved in a time-limited setting and so manage expectations accordingly. In practice, this could include, for example, introducing to the client at an early stage in the contract the idea that their personal journey towards wellbeing and realizing of potential continues long after the therapy has ended.

Taking stock:

By offering a forum to subsequently reflect, review and appraise, the research interviews were expressly welcomed by all participants and deemed to be an integral part of their therapeutic process. Indeed some participants suggested that without this, much learning potential from the actual sessions would not have been realised. Therefore, in terms of clinical practice, providing an opportunity to review and evaluate what has been achieved in relation to the original presenting issues and objectives, can be a substantive enhancement and fortifier of the overall process. Of course reviews should not replace the continual 'checking-in' throughout therapy contracts that good relational practice demands but by formally building-in a review stage into the overall process ensures it occurs, and the associated benefits realised. Again to return to some of the core characteristics and intentions of CoP (i.e. client empowerment and facilitating a focus upon wellbeing and potential); perhaps for us as practitioners to comprehensively attend to these actually makes reviews especially important in time-limited practice. Checking with the client that they are managing to integrate and develop what they have learned in the limited sessions they had.

Further, there is significant value in such reviews being conducted by someone other than the therapist since this can facilitate a greater degree of candour and depth of appraisal. Therefore, providers might consider arranging for the original assessment therapist to conduct the post-therapy review session(s) if possible within the agency structure. They should also consider conducting a review after an elapsed period, perhaps similar to that employed in this research (twelve weeks from ending), but certainly a period from which it can be reasonably assumed that the client has had time to integrate, experience and so evaluate any therapy gains.

Finally, post-therapy reviews convey an impression of professional after-care and a more personalised, tailored service – and much less of a conveyor-belt experience. This is important to consider, particularly so for large-scale service providers. Indeed from a resource perspective, there could well be an economic advantage also to consider if one result of a more comprehensive therapy experience is a reduction in the rate of re-presenting clients.

5.4.4 Clarification of research contribution scope

When considering the overall contribution of this research, it is important to also be clear on what claims *cannot* reasonably be made from the findings. Firstly, and to reiterate the point made earlier in the Method chapter (*section 3.3*); given this is an idiographic study, there has been no attempt nor intention to produce generalizable conclusions or develop theories attributable to a wider population. Rather, this has been about providing an arena for a small group of service users to consider and give voice to their experience of a particular type of therapy in a particular setting. From this, the intention has been to appraise ETLT's effectiveness in addressing their specific presenting issues, needs and objectives.

To this end, the setting is in itself central to considering the context and scope of the findings and the subsequent conclusions that have been drawn from them. As outlined in *Chapter 1* and *3*, HCS is a counselling service for primarily MSM who are affected in some way by HIV and other sexually transmitted infections. It is also aimed at MSM impacted by their experience of being sexual in a non-conforming way. The participants to varying degrees presented at HCS with issues and difficulties relating to both. However, the findings show how their fear of rejection and persecution, need for acceptance and relatedness, and general sense of isolation were all most associated with being gay in the world.

Therefore, in terms of the relevance of existential therapy for addressing the reported presenting issues and objectives of this particular client group, my central conclusion is that ET has been shown to have been of considerable value and notable effectiveness, and as such is worthy of serious consideration as a treatment option. Specifically, and has been argued in the preceding sections, the core defining characteristics of ET (the emphasis on relatedness and the therapeutic relationship; a normalising and non-pathologising attitude; focus upon understanding and meaning-making; empowering through encouraging responsibility and choice; and, crucially, accepting the Other and their 'otherness' without an assumption of change) were together experienced by the participants as effectively attending to their problems with living. However, and again reflective of this being an idiographic study, we

cannot draw any similar such conclusions from the current findings in terms of effectiveness beyond this particular setting and this particular client group.

Similarly, it is important to emphasise that there is no suggestion that ETLT is *more* suitable than any other approach - nor can there be since there was no such comparative analysis. There is equally no claim in terms of research contribution that the time-limited approach in itself is in any way superior to, or more effective than, open-ended or longer-term therapies. Again, in the absence of a comparative research design, no such conclusions are made or intended. All that can be reflected from these findings in terms of the frame is that these participants reported a sense of urgency and focus which they specifically attributed to the explicit time-limited aspect of the therapy.

Having outlined the research contributions in terms of counselling psychology theory and practice, I turn now to an appraisal of the design limitations of the current research as well as offering suggestions for further related studies.

5.5 Design clarifications and ideas for future research

A primary intention throughout this research process has been to offer a robust contribution to the knowledge-base of the counselling psychology discipline. As part of this evaluation, I have identified a number of areas that are worthy of consideration for future investigation and which are detailed below in section *5.5.2*.

First, however, and as perhaps is inevitable with most research; during the planning and implementation phases some design issues emerged. For the purpose of research transparency as well as to assist any future researchers in their design considerations, I outline each of these below (in no significant order).

5.5.1 Design limitations and clarifications

1. Based upon the literature review and identified gaps in knowledge, I approached the design stage of the research with clear ideas around what I wanted to explore. Specifically, I

had distinct areas of the wider phenomenon of ETLT that I had concluded where of particular worth in focussing upon. I readily accept that this could seem to run counter to a central feature of IPA; that it be purposefully participant-led, characterised by semi-structured questioning intended to facilitate a non-directive exploration of the participant's experience. A key aspect of this is, of course, the minimising of any pre-conceived ideas or assumptions of the researcher.

I agree that these fundamentals of an IPA research design to be crucial and consider my actual interview questions to have been appropriately open and facilitative of whatever the participants chose to explore – albeit within pre-defined areas. The intention has been a non-directive enquiry of more specific phenomena within a wider phenomenon. Without doing so, the particular aims of the research may not have been satisfied and the potential afforded by my participants generously and courageously offering their time and knowledge for the purpose of enhancing our knowledge could, I believe, have been substantially reduced. For example, since I wanted to understand *how* the therapeutic relationship contributed to outcome, without specifically asking the (I would argue open and phenomenological) question '*what was your experience of your therapist*?' I may not have been able to reasonably suggest my data in any way attended to this identified gap in knowledge.

In other words, my view is that greater depth and focus upon gaps in the knowledge-base was achieved by the research questions set. Whilst acknowledging this inevitably meant a researcher-led element to the interview design, my view is that the IPA protocols (e.g. see Smith (2010) and as described in section *3.3.1*) allow for this as well as protect against it being over-reached by way of analysis transparency.

2. Following from the above, I turn now to what I suggest is a strong ethical argument in favour of conducting follow-up interviews, particularly when the research participants are, or have been, service users and so are disclosing and engaging with potentially affecting issues. In conducting these, a primary purpose was to ensure that I could then analyse the data and report my subsequent findings based upon a robust and comprehensive understanding of the experiential accounts. As shown in Chapter 3 (section 3.4), Flowers (2008) argued that the

potential for lost opportunities is high due to the elevated 'cognitive load' for the researcher when so much is wanted and expected from a 'one-chance' interview. I added that this can be perhaps especially so for the novice IPA researcher.

In this research, where I was uncertain of what was being conveyed in the initial interviews, for example where there appeared to be ambiguity, the follow-ups afforded me a valuable opportunity to revisit and clarify. I could then argue with an enhanced degree of confidence - with the follow-up data to support my findings - to be reasonably reflecting the participants accounts. For this reason, I propose it is ethically sound and in fact appropriate to have a two (or more) interview design in IPA studies with service users. When we are afforded the privilege of people sharing their personal experiences for the future wellbeing of others, it is our ethical duty as researchers to ensure that we analyse and report the resulting data as thoroughly and accurately as possible. Follow-up interviews have been shown in this research to significantly contribute to that goal.

3. I explained the rationale behind the twelve-week elapsed period between initial and follow-up interviews in section *3.5.5 (Interview Design)*. However, to briefly reiterate here, the principle purpose of the follow-up interviews was to provide the opportunity for clarifications on comments made in the initial interviews as well as for any other subsequent reflections. I recognise that twelve weeks was a significant time period from the perspective of accuracy of recall, and so I acknowledge the potential for memory degradation between interviews. However, I also maintain the view that some greater depth and reflection was in fact gained in the follow-up accounts by allowing this substantive period of time to pass. This depth was reached by allowing a time for assimilation of the experience and integration of any therapeutic outcomes into the participants' lives.

4. All participants' therapists self-identified as existential practitioners and I accepted this as evidence enough that their practice was therefore indicative of the existential approach. There was an assumed level of similarity amongst the HCS therapists in terms of their training and experience in that all were qualified therapists and in advanced stages of doctoral existential counselling psychology training programmes. While my research was intentionally

focussed upon the experience of the participants, as part of my selection criteria process it may well have been useful to have formally clarified with the practitioners involved their qualifications and credentials; and indeed their level of experience of working in a time-limited setting.

5. The research sample was deemed homogeneous for the following reasons: all had very recently attended (as a first tranche) twelve sessions of time-limited therapy at HCS with an existential therapist; all were male and aged within a ten-year range (34-43); and all identified as British although of varied ethnicities. There was variance in terms of HIV status: one recently diagnosed as HIV-positive, two had been HIV-positive for several years and one was assumed negative. This variance would have been considered problematic if I had been specifically investigating the existential approach with regards to a specific presenting issue – e.g. an HIV diagnosis. However, my primary focus was instead on the process and experience of existential therapy in a particular setting and not of a particular presenting issue. This said, significant data was acquired in relation to the experience of being recently diagnosed as HIV-positive from one of the participants, and living with HIV long-term from others; all of which I hope to make use of in future work.

6. This research has been concerned with appraising a therapeutic approach from the perspective of clients who cannot be assumed to have any theoretical knowledge of the discipline under investigation. In large part, this was the core intention of the research – to gain insight from actual service users rather than professionals. Nonetheless, I acknowledge that where I draw conclusions in terms of theory, these are informed by my knowledge and understanding as a researcher-practitioner.

7. Early in the planning stages, I tried to secure agreement from HCS managers to gain access to my participants' *CORE-OM* data for the purpose of conducting a comparative analysis of their outcome scores against the qualitative data. However, due to confidentiality concerns, the agency declined this request. Being able to analyse the qualitative data against participant-reported outcome measurements could well have been informative. This said, it would also have changed the emphasis of my research considerably from a qualitative study

that was explicitly focussed upon experiential accounts.

5.5.2 Ideas for future research

1. I referred at the outset of this thesis to the existential crisis that counselling psychology currently finds itself in and which some influential commentators have warned of the serious associated implications for the profession (e.g. Deurzen, 2010; Woolfe, 2012). To stand a fighting chance of remaining a distinct discipline, and resisting the slide towards absorption by clinical psychology, requires attending to the demand for outcome measurements. This demand comes above all from the service policymakers and commissioners and cannot be ignored or disregarded; they need clear evidence of efficacy to justify their spending decisions. So to be part of major services such as the NHS and the funding-dependent third sector requires a strong degree of pragmatism with regards our attitude to developing an 'evidence base' of effectiveness and viability. This said, in terms of suggestions for future research, I add first my voice to the call for more qualitative research that accentuates the subjective experience of therapy by service users, in line with our philosophical underpinnings.

However as well as this, where quantitative data can enhance or complement this client-centric knowledge, I concur with those who argue that we should embrace it (e.g. Cooper, 2010; Rayner & Vitali, 2013; Vos, 2013). We must welcome all information that serves to enhance our practice and the wellbeing of our clients. This is the ethical attitude and indeed could serve to increase the reach of existential counselling psychology to those most in need. The promising research currently being conducted by Rayner and Vitali which specifically seeks to quantitatively measure (by reference to CORE-OM scores) the efficacy of brief (6 session) existential therapy would appear to be attempting to strike such a balance. This is equally true of the ongoing development of wellbeing scales and outcome questionnaires for existential therapy by Tantam and Blackmore (yet to be published). Any further research that blends qualitative and quantitative elements in investigating ET could also prove to be particularly worthwhile and timely contributions.

2. Strasser and Strasser (1997) refer to there being a more concentrated amount of

therapist interventions in the time-limited approach, reflective of the intensified pace. While my participants reported a general sense of urgency and focus in their contracts, the data did not produce specific examples of this. During the design phase of my research, I had discussed with HCS managers the possibility of participants maintaining a diary *during* their therapy contract in which they would be asked to record their session-by-session experiences. HCS declined my request citing the risk of compromising client-therapist confidentiality to be too great. Were some such design to be successfully negotiated for future related research, it would provide us with more immediate reflections of how the therapy is being experienced as it progresses, rather than relying on entirely retrospective accounts.

3. With regards to the presenting issues reported in this research, the pervasive impact of shame and its' relationship with being LGB in the world today I suggest merits substantial and focussed investigation. This is needed in order to further develop our understanding of how obstructive this can be to the psychological wellbeing for so many men and women.

4. The inherent intimacy of the therapeutic relationship that was readily evident in the current research is especially worthy of substantial focus in order to better inform us of what can be a challenging area for practitioners. This is of course especially important for ET, which embraces the relational attitude and approach.

5. Differences of gender, culture, vernacular and sexuality emerged as contributing factors in affecting relationship development. Further specific research of such concepts would be useful in order to continue to enhance our understanding of the contributors to meaningful therapeutic alliances. Moreover, the facilitative potential of both personal disclosure and humour from the therapist were also evident. While these were not of sufficient strength to warrant being included as definitive themes here, future research of these important factors could prove enlightening.

6. One participant referred to the value of the physical presence of the therapist – the *being-with*; implying that was in itself an important aspect in the development of the therapeutic relationship. Given the increasing prevalence of telephone and online counselling

services that are now being offered as alternatives or replacements to the traditional face-to-face, I suggest research in this specific area is needed.

Collectively, the above points are some ideas for those interested in this area of study and are by no means intended nor assumed to form an exhaustive or definitive list. The reader may well have their own ideas of what might be useful or pertinent for the continued development of knowledge in this area; any and all of which are very much welcomed by the present author.

Having discussed and evaluated the findings within the context of the existing literature as well as in terms of implications for clinical practice and contribution to knowledge, in the following and final chapter I offer an overall evaluation and conclusion of this project.

6. Conclusion

This research shows that ETLT can be a highly effective therapeutic experience explicitly *because* it acclaims the individual and adopts an unequivocally accepting attitude to difference. In being neither prescriptive, nor technique-laden, and instead fundamentally relationship-focussed, ETLT offers an inherently client-centric and empowering type of therapy, positioning the client at the vanguard of their journey to wellbeing.

Time is present in all that we do; indeed it is the essence of our existence. We live and will die within a temporal world, and I have discussed how this understanding of the lived experience underpins existential theory and practice. The current research endorses the argument first proposed by Strasser & Strasser (1997) that ETLT's engagement with temporality uniquely positions it within time-limited CoP practice; specifically because it is informed by our own 'time-limitedness' and so seeks to harness and encourage a sense of purpose, vitality and urgency to life, while one has it.

ET practitioners have, generally speaking, been somewhat reluctant to work within a time-limited framework, resisting any 'one size fits all' approach for addressing their client's unique problems with living. However, time-limited practice is undoubtedly and unavoidably the standard means of therapy provision for economically-constrained services in the UK today, and this is unlikely to change. Therefore, if ET practitioners want their therapy to be included as a treatment choice then, as Cooper (2003) suggested, they will have to at least pragmatically accept this reality. However, I think we can approach this from an altogether more positive perspective and see this as an opportunity for ET to work in a structure that it is eminently suited to. So while Deurzen (2002) argued that there can be no '*quick fixes*' in therapy, I would say that while this is certainly often so, the current research suggests that nor should we assume discovering one's route to personal wellness requires many months or years in therapy.

I referred in Chapter 2 to the existential crisis that CoP currently finds itself in and which influential commentators from within the profession have warned of (e.g. Cooper, 2011; Deurzen, 2010; Woolfe, 2012). Namely, that as a response to the inexorable demand for evidence-based practice, CoP is at risk of losing sight of the very characteristics that both define and distinguish the profession within the applied psychologies: pluralism, the acknowledgement of subjectivity, and understanding problems within the historical, socio-political contexts and relational matrix in which the client – and we - exist.

In fact, these defining characteristics of CoP, and treatment options that reflect them, have been no more imperative than they are now in a world enthralled by the incredible march of science and technology, and wedded to the standardised application of 'proven' methods. For this is also a world in which our often hectic lives have evolved in such a way that we are in many ways more connected than ever (e.g. through the omnipresent social media) and yet more relationally detached and isolated. This is reflected in the alarmingly elevated rates of mental illness in large cities (Health and Safety Commission, 2010; Milton, 2010). Lived experiences, incidentally, that can only be all the more intensified for those fearing persecution and rejection on account of their non-conforming sexuality.

These are problems with living and relating in a sometimes hostile and certainly complex world. A therapeutic approach that is actively relational, accepting and empowering holds much potential for those in need. This research has shown ETLT to be eminently attuned to these aims. Therefore, the hope has to be that ETLT's current lack of representation in major service provisions can change since it has much to contribute. Its inclusion as a treatment option can surely only serve to bolster CoP's plurality at a time when this is being so undermined. Protecting and enhancing this pluralism where we can is an ethical responsibility for all within the profession, for it is this that ensures clients are afforded choice in a realm where there is no single right way. In doing so, we empower and enable our clients to choose *their* route to wellbeing.

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Appendix i: Ethical Approval Application Documentation

Psychology Department

REQUEST FOR ETHICAL APPROVAL

Applicant (specify): *Neil Lamont*

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials, (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other, including approval by collaborating institutions). A fuller description of the study may be requested.

- Is this the first submission of the proposed study? Yes
- Is this an amended proposal (resubmission)? No
- Is this an urgent application? (To be answered by Staff/Supervisor only) No

Supervisor to initial here_____

Name(s) of investigator(s) NEIL LAMONT

Name of supervisor(s) ELENA MANAFI

Title of study: An investigation of the experience of time-limited counselling psychology from the perspective of users of an HIV Counselling Service

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions? YES

If "yes", what precautionary steps are to be taken?

Participants will be asked to reflect on an experience they have had and since they would be electing to take part while being furnished with comprehensive details of the purpose of the study and what will be involved, the intention is that they will be able to make an informed judgement for themselves if this is an acceptable level of risk that they are prepared to take. However, it will also be made explicit to participants that they will be able to end the interview at any time. Further, the information sheet will advise that there may be a possibility that talking about one's experience of counselling could generate uncomfortable feelings and that, should this be the case, they will be offered options of support.

At the end of the interview the participant will be debriefed to establish their current state. They will be asked to reflect on the experience of the interview and how they feel now. In the event that my interviews evoke any upset or distress in the participant, they will be offered the opportunity of exploring this with me immediately after the interview. Further, since they are clients of HCS Counselling Service, they automatically have the option available to them of commencing a new (free at point of use) contract of counselling should they feel the need. However, this can only be offered after twelve weeks have elapsed since the end of the previous contract, therefore in the event of an urgent and immediate need for counselling support, the participants will be supplied with the HCS Direct support helpline telephone number and also offered the option of contacting HCS Connect, a low-cost service provided by the same practitioners as the free service but with no such elapsed-time restrictions (i.e. can begin this anytime).

3. Will any form of deception be involved that raises ethical issues? NO

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry or humiliated when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here ……. and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? *(A full risk assessment must be conducted for any work undertaken off university premises)*[6,7]

Participants will be recruited through HCS Counselling Service – with the co-operation of the Counselling Service practice manager.

5. Does the study involve

Clinical populations	NO
Children (under 16 years)	NO
Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?	NO

6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? (*See consent guidelines*[2]*; note special considerations for some questionnaire research)*

Consent to be gained from participants – they will be asked to read the Participant Information Sheet and sign the corresponding consent form, if agreeable to them. They will also be given my contact details should they have any supplementary questions before the interview takes place.

7. Will you inform participants of their right to withdraw from the research at any time, without penalty? (*see consent guidelines*[2]*)* YES

8. Will you provide a full debriefing at the end of the data collection phase? YES (*see debriefing guidelines*[3])

9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? YES

10. Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed? (*see confidentiality guidelines*[5]) YES/NO

If "yes" how will this be assured *(see[5])*

Anonymity is assured. The digital recordings and transcripts will be digitally encrypted and secure (in compliance with the Data Protection Act 1998). No names or identifying characteristics will be published in the dissertation or article. This will be explained to the participants in the Information Sheet.

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form? NO

(NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should be provided -- if necessary, on a separate sheet submitted with this form).

	Yes	No
12. Some or all of this research is to be conducted away from Middlesex University	●	
If "yes", tick here to confirm that a Risk Assessment form is to be submitted	●	
13. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	●	
14. I am aware that I need to keep all materials/documents relating to this study (e.g. participant consent forms, filled questionnaires, etc) until completion of my degree	●	
15. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human participants*[4] and believe this proposal to conform with them	●	

Researcher…… date ……..

Signatures of approval: Supervisor……. date ……..

Ethics Panel ……. date ……..

(signed, pending completion of a Risk Assessment form if applicable)

Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed.

I intend to explore the subjective experiences of users of a time-limited counselling service for people affected by HIV (and receiving counselling from practitioners identifying themselves as 'existential') by inviting service users to a semi-structured interview (I aim to secure around four participants for this research). I will invite these participants to a follow-up interview twelve weeks later to explore if what has endured from the work. There has been little research to date that seeks to identify what is useful in the work, from the client's perspective, and to consider this against existential concepts such as temporality and death anxiety that suggest this particular mode of working is especially pertinent to working with people faced with this health crisis.

Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants,

As detailed earlier, care is being taken to ensure the voluntary basis of the participants. Furthermore, an information sheet will be provided to the participants well ahead of time in order to ensure that they are aware of the subject matter, and that they can opt out at any time. Should the participants experience emotional difficulties (since they are being asked to recount experiences of their counselling), they will be offered support from the interviewer (current author) and provided with new counselling options from the HCS Counselling Service.

Session length

Interviews are expected to last around one hour and a maximum of ninety minutes. The follow-up interviews are expected to be less than the above, most likely around thirty to sixty minutes.

Procedures

Participants will be invited to a semi-structured interview to explore and discuss their experience of Existential Time-Limited counselling. The interviews will be conducted at a neutral location, in a counselling room in a well-staffed and safe building. This will form the basis of the qualitative component of the research. Participants will be invited to a 'follow-up' interview around twelve weeks later (to explore if the experience they have reported initially has endured – and in what ways).

Note: The agency have indicated that it is their preference that I conduct the interviews offsite – the reason being that after initial contact with participants through the agency, the research is considered to be then independent from the agency, and as such should be seen to be so. Also, the feeling is that if the interviews were to be onsite, this may 'contaminate' the participants responses, in that they may feel less inclined to be candid about negative experiences at the counselling service.

With this in mind, the interviews will be conducted at a neutral location, in a consulting room I will rent-out at The Psychosynthesis Education Trust, Tooley Street, London. Interviews will be conducted

during regular hours and at a time when several staff are in the building (and neighbouring consulting rooms are being used by practitioners). Should this location be unsuitable to potential participants, I will source an alternative room at a location more convenient to them but with the same or similar features to the above, to ensure safety.

Stimuli

The stimuli will be the interview questions, that will, until the interview, be unknown to the participant. However, the subject matter has been clearly explained in the information sheet provided beforehand.

Responses

The responses are the answers and reactions from the participants, which will be digitally recorded and transcribed.

Data collection

The interviews with participants will be digitally recorded and subsequently transcribed to allow the IPA method of analysis (Smith and Osborn, 2003) to be conducted.

Storage and reporting of data

The digital recordings of the interviews will be securely stored on an encrypted hard drive (using TrueCrypt in AES mode, NSA Top Secret cleared) (CNSS, 2003).

The data will be anonymized prior to publication by the omission or change of names, and all other details to ensure the confidentiality of participants is maintained.

References:

CNSS., (2003)	U.S. Committee on National Security Systems (CNSS). National Policy on the Use of the Advanced Encryption Standard (AES) to Protect National Security Systems and National Security Information, CNSS Policy No. 15, Fact Sheet No. 1, June 2003. Accessed August 2009 from csrc.nist.gov/groups/STM/cmvp/documents/**CNSS15**FS.pdf .
SMITH, J.A. and OSBORN, M. (2003)	'*Interpretative phenomenological analysis'* in Qualitative Psychology: A Practical Guide to Research Methods. Sage Publications: London.

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

1. *All fieldwork undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Fieldwork undertaken by research students. Student to complete with supervisor.*
4. *Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.*

FIELDWORK DETAILS

Name NEIL LAMONT

Student No

Research Centre (staff only)……

Supervisor ELENA MANAFI

Degree course DPsych (Counselling Psychology)

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name Salvatore De Cicco

Phone 07852 636359

Physical or psychological limitations to carrying out the proposed fieldwork

None

Any health problems (full details)

None

Which may be relevant to proposed fieldwork activity in case of emergencies.	
Locality (Country and Region)	London, United Kingdom
Travel Arrangements	Walking from home to interview room, or public transport to alternative locations in Central London.
NB: Comprehensive travel and health insurance must always be obtained for independent overseas fieldwork.	N/A
Dates of Travel and Fieldwork	April 2010 (specific dates to be confirmed).

PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment PLEASE READ VERY CAREFULLY

List the localities to be visited or specify routes to be followed **(Col. 1).** Give the approximate date (month / year)

of your last visit, or enter 'NOT VISITED' **(Col 2).** For each locality, enter the potential hazards that may be identified

beyond those accepted in everyday life. Add details giving cause for concern **(Col. 3).**

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)

Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.

Demolition/building sites, assault, getting lost, animals, disease.

Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.

Lone working: difficult to summon help, alone or in isolation, lone interviews.

Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.

Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.

Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies,

fitting) general fitness, disabilities, persons suited to task.

Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.

Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.

Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

Give brief details of fieldwork activity: Interviewing users of a counselling service re their experience of it.

1. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
Psychosynthesis Education Trust, Tooley Street, Central London, SE1. **Also, potential other rented consulting room nearer to participants home if above address not suitable.**	**September 2009**	**1. Lone working – the interviews will be conducted by me with the participant and no other in the room.** **2. Dealing with the public – as detailed in this form, there is a potential risk of causing offence or intrusion as well as cultural differences.** **3. Failure of equipment – breakdown of digital recorder.**

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning

and conducting fieldwork.

Risk Minimisation/Control Measures PLEASE READ VERY CAREFULLY

For each hazard identified **(Col 3),** list the precautions/control measures in place or that will be taken **(Col 4)** to **"reduce the**

risk to acceptable levels", and the safety equipment **(Col 6)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 4),** categorise the fieldwork risk for each

location/route as negligible, low, moderate or high **(Col. 5).**

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions

and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant

risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

PRECAUTIONS/CONTROL MEASURES	RISK ASSESSMENT	EQUIPMENT
1. Potential Risk: Lone working – the interviews will be conducted by me with the participant and no other in the room. CONTROL = The building where I will conduct interviews is heavily staffed, with several other individuals on the same floor. Interviews will be conducted at times that are within standard operating hours of the premises and as such there will be no time when I am alone in the building with the participant. In terms of working alone in the room, I will have a mobile phone and safety alarm for attracting attention in the event that they are required. Similarly, should the requirement be to meet a participant at an alternative location (e.g. if the above address is problematic for them to reach) alternative sourced interview rooms will be in similarly staffed buildings.	Low	Mobile phone, safety alarm
2. Potential Risk: Dealing with the public – as detailed in this form, there is a potential risk of causing offence or intrusion as well as cultural differences. CONTROL = Participants will be asked to reflect on an experience they have had and since they would be electing to take part while being furnished with comprehensive details of the purpose of the study and what will be involved, the intention is that they will be able to make an informed judgement for themselves if this is an	Low	

acceptable level of risk that they are prepared to take. However, it will also be made explicit to participants that they will be able to end the interview at any time. Further, the information sheet will advise that there may be a possibility that talking about one's experience of counselling could generate uncomfortable feelings and that, should this be the case, they will be offered options of support. As well as this, at the end of the interview the participant will be debriefed to establish their current state. They will be asked to reflect on the experience of the interview and how they feel now. In the event that my interviews evoke any upset or distress in the participant they will be offered the opportunity to explore this with me immediately after the interview. Should the feel the need for further exploration, since they are clients of HCS Counselling Service, they automatically have the option available to them of commencing a new (free at point of use) contract of counselling should they feel the need. However, this can only be offered after twelve weeks have elapsed since the end of the previous contract, therefore in the event of an urgent and immediate need for counselling support, the participants will be supplied with the HCS Direct support helpline telephone number and also offered the option of contacting HCS Connect, a low-cost service provided by the same practitioners as the free service but with no such elapsed-time restrictions (i.e. can begin this anytime).	Low	
3. Potential Risk: Failure of equipment – breakdown of digital recorder. CONTROL: I will take an additional recorder with me, in the event there is a problem with my primary recorder.		Take secondary recorder with me in event of failure of principle recorder.

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no

significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work

have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork

discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff)	……	**Date**	……
Signature of Student Supervisor	……	**Date**	……

APPROVAL: (ONE ONLY)

Signature of Curriculum Leader (undergraduate students only)	……	**Date**	……
Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader	……	**Date**	……
Signature of Research Centre Head (for staff fieldworkers**)**	……	**Date**	……

FIELDWORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant):

   x Safety knowledge and training?

   x Awareness of cultural, social and political differences?

   x Physical and psychological fitness and disease immunity, protection and awareness?

   x Personal clothing and safety equipment?

   x Suitability of fieldworkers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant

   authorities been consulted or informed with regard to:

   na Visa, permits?

   x Legal access to sites and/or persons?

   na Political or military sensitivity of the proposed topic, its method or location?

na	Weather conditions, tide times and ranges?
na	Vaccinations and other health precautions?
x	Civil unrest and terrorism?
x	Arrival times after journeys?
na	Safety equipment and protective clothing?
x	Financial and insurance implications?
x	Crime risk?
x	Health insurance arrangements?
x	Emergency procedures?
x	Transport use?
x	Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix ii: Confirmation of ethical approval

New School of Psychotherapy and Counselling

Director: Prof. Emmy van Deurzen

Royal Waterloo House
51-55 Waterloo Road, London SE1 8TX.
Telephone: 020 7928 4344/0029
Fax: 020 7401 2231
Email: admin@nspc.org.uk
Website: www.nspc.org.uk

Neil Lamont
Flat 10
79 Rouel Road
London
SE16 3SL

19th May 2010

Title of Study: *An investigation of the experience of time-limited counselling psychology from the perspective of users of an HIV Counselling Service*

Dear Neil

Re: Ethics Approval

I can now confirm that your project has been approved.

Congratulations!

Yours sincerely

Prof Digby Tantam
Chair - Ethics Committee
NSPC

Appendix iii: Participant Information Sheet (PIS)

JOINT RESEARCH ETHICS COMMITTEE OF THE NEW SCHOOL OF PSYCHOTHERAPY AND COUNSELLING AND THE SCHOOL OF PSYCHOLOGY OF MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET

1. Invitation:

The following information is provided for you to decide whether you wish to participate in the present research study being undertaking for the Counselling Psychology doctoral programme at Middlesex University.

Prior to deciding to participate in this study, it is important that you understand what the purpose of the research is and what it will involve, so please read the information below carefully. If there is anything that is not clear or you would like more information about please do not hesitate to ask. After reading the information please take some time to consider whether or not you wish to participate. Your participation could help us better understand users' experience of the counselling service.

2. Research title:

'An investigation of the experience of time-limited counselling from the perspective of users of an HIV Counselling Service.'

3. What is the purpose of the study?

To establish what users of the Counselling Service found to be particularly useful and effective, as well as perhaps what did not work especially well for them. Service users complete 'CORE' questionnaires at the beginning and end of their counselling contract which is very useful, but by gaining some more detail around what actually happened during the sessions we can learn more about the service provided and in what particular ways it can help (and perhaps even be improved). This can best be done by talking to people such as you who have recently had counselling at HCS to hear first-hand about their experiences.

4. Why have I been chosen?

You have recently completed counselling with a counsellor at HCS on a time-limited setting (probably seeing your counsellor for up to twelve weeks), and indicated at the time of your assessment that you would consider participating in research. This research is seeking to hear about your experience of that counselling.

5. Do I have to take part?

No. Your participation in this research is entirely voluntary (but would be greatly appreciated). You would be asked to talk to me about your recent counselling. Please consider whether you feel able to do this before you sign the consent form, as the questions may bring back feelings and memories about issues you covered in your counselling. You may choose not to answer any question during the interview, which is also perfectly acceptable. If you decide to take part you may withdraw at any time before, during, or after the interviews without justifying your decision. HCS will not be informed whether you agree to do the interview or not, nor would they be informed if you change your mind and want to withdraw.

6. What will happen to me if I take part?

I would like to interview you on two occasions, each of which will last for about an hour. We will discuss how things were for you in the counselling sessions you have had at HCS. The first interview will be very soon after you have ended your counselling and then a second follow-up interview, in which you will be asked to offer any further thoughts, will be held twelve weeks later.

7. What do I have to do?

Taking part in the research will involve participating in two 'semi-structured' interviews, in which you will be asked about your counselling. There will be no right or wrong answers to the questions. All that is required are your particular opinions and thoughts about your experience.

Interviews will take place in a private counselling room at London Bridge (at the Psychosynthesis Education Trust, Tooley Street, SE1 – very close to London Bridge underground station). If this location is not convenient for you, I will travel closer to you and can arrange for a similar room to meet. You will not be paid for participating, however, your travel expenses will be reimbursed.

8. Is there any risk in taking part?

Some of the questions may bring back feelings for you that you might find difficult and feel you need to talk about. We can talk about this while we are still together (I am an accredited psychotherapist). Alternatively, you are very welcome to contact either HCS Direct for some confidential advice (tel xxxx), or the HCS Counselling Service (tel xxxx) who will be able to discuss with you a new counselling contract.

9. What are the possible benefits of taking part?

Your answers will inform research that seeks to benefit the understanding of the counselling service that is provided at HCS. Contribution of knowledge to the field can lead to an enhanced service and ultimately the promotion of wellbeing for future users of this, and similar HIV counselling services.

10. Will my taking part in this study be kept confidential?

Yes. All information provided by you during the research will be kept strictly confidential. All data collected will be stored, analysed and reported in compliance with the Data Protection Act 1998. You will have right of access to personal data collected about you as part of the research. Should you wish to do so, please make a request in writing to the address at the end of this information sheet. Your details and interview recordings will be allocated an alphanumeric code. A record of any personal records, such as name, date of birth, address and sensitive personal data, will be kept separately to protect your anonymity. When quotes from the interviews are used in the research thesis, any information which could identify you will be changed.

11. Recordings:

The interviews will be digitally recorded then immediately encrypted and kept in a secure place separate from your personal details. The supervisor may ask to see the data collected prior to anonymization but otherwise please be assured that there would be no other individuals involved who could request seeing the data until it has been anonymized. After the study has been completed and research findings published, the recording will be deleted. Should you wish for the recording of your interview to be erased at any time beforehand, this will be arranged (without question).

12. What will happen to the results of the research study?

The research will be published as part of a doctoral thesis and will be lodged in the University Library. Should you wish to read the final research you can request to receive a brief summary or a copy of the completed thesis. Should you agree to take part in the research, please indicate which, if any, of these you would like sent to you (you will be asked to confirm this at the end of the interview).

13. Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The research has received approval from the joint Research Ethics Committee of the New School of Psychotherapy and Counselling and the School of Psychology of Middlesex University. Should you have any complaints about the research you can contact the supervisor, please see details below. The indemnification procedure of Middlesex University applies to the research.

14. Contact details:

Should you decide to take part, please contact me at: counsellingresearch@gmail.com or telephone 07980 078477.

Researcher: **Neil Lamont** *(MBACP Accred.)*

Supervisor: **Dr Elena Manafi**

New School of Psychotherapy and Counselling (NSPC)

Royal Waterloo House

51-55 Waterloo House

London SE1 8TX

NSPC telephone number: +44 207 928 4344

NSPC email address: admin@nspc.org.uk

Thank you very much for taking the time to consider participating in this research.

Appendix iv: Participant Consent Form

Middlesex University School of Health and Social Sciences

Informed Consent

Participant ID:

Researcher: Neil Lamont

Study title: An investigation of the experience of time-limited counselling psychology from the perspective of users of an HIV Counselling Service.

I have read the details of the research in the Information Sheet, had the opportunity to ask the researcher any questions, and confirm that I have consented to act as a participant. It has been explained to me that I will be asked to return for a follow-up interview as part of this study.

I understand that my participation is entirely voluntary, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I understand that my interview will be digitally recorded, subsequently transcribed and anonymized using an alphanumeric code. I further understand that the data I provide may be used for analysis and subsequent publication (with my anonymity assured), and provide my consent for both.

_____

Name of participant Date Signature

_____

Researcher Date Signature

(1 copy for participant; 1 copy for researcher)

APPENDIX v: First Interview questions

Areas to be explored in the interview:

- ***Presenting issues and objectives*** *- what were the participants' hopes and expectations as they began the existential time-limited therapy at HCS?*
- ***The therapeutic process*** *– what, if anything, actually emerged for the participants during the therapy contract*?
- ***Outcome*** *- what, if anything, did the participants take from the therapy and how have they been affected by it?*
- *How did the participants' experience the* ***therapeutic relationship*** *in this setting?*
- ***The time-limited frame*** *- did this influence the work for the participants in any way and if so, how?*

Interview questions:

Welcome and introduction:

I introduce myself and ask the participant if they have read the PIS and if they have any questions before we begin.

High –level information:

Can we begin by me firstly just clarifying some details with you?

Can you confirm for me when you had the counselling and how many weeks you attended for?

At assessment, clients are usually asked if they have any particular preferences (e.g. in terms of therapist gender), can you remember if you had any such preference?

Presenting issues/objectives:

Can you tell me something about what brought you to counselling?

OK, so now I'd like to talk about what your expectations might have been when you came to HCS. What, would you say, you hoped to achieve from the counselling?

Therapeutic process:

So given what you have said so far, in terms of what brought you to HCS and what you hoped to achieve from it, can you have a think now about what emerged in the work…

What, would you say, were the major issues or themes that came-up for you?

- Can you give some thought now to what worked well for you (if anything)? Can you tell me about that?
- And now, would you say there is anything that you felt was not useful? Can you tell me more about that?

Therapeutic relationship:

(*if not already emerged in conversation so far)*

I'd like to talk now about your experience of the counsellor, and just to remind you that this is confidential and I don't know who your actual counsellor was, I wonder if you can tell me what was your experience of him/her?

Time-limited frame:

Can we now have a look at the number of sessions you had? You said at the beginning you had x sessions…can you say something about that? (*note – I'm looking here to keep this as open as possible, but will prompt if necessary to establish did it feel long / short / too much / too little / just enough / did it go quickly / were some sessions slower than others*)

Were you aware from the beginning of your sessions, that there was a limited number available to you? (Is this something you talked about as the weeks progressed? Can you describe if you had any thoughts or feelings about there being a ltd amount available to you?)

Outcome:

Just a few more questions left. I'd lastly like to ask if, looking back, you can say if your expectations were in fact met?

Would you say that your aims/objectives were achieved?

How has life changed, if at all, for you having had the counselling?

Would you use the service again?

Closing of interview:

Thank participant, ask them to reflect on the experience of the interview, how do they feel, ask if they have any questions for me, and if they will still be willing to take-part in a follow-up interview – which should be shorter and could be done by telephone, if preferred – to establish if some of the things they have said today, still apply.

Appendix vi: Follow-up Interview questions

note – this was unique in part for each participant based upon aspects I sought clarification on from the initial interview. I include the interview script for one participant here as an example only

Begin interview by explaining:

The purpose of the follow-up here is to give you the opportunity to share any further thoughts you have had following the first interview.

So can I ask if there is anything you would like to share now….any more thoughts?

Repeat questions (from initial interview)

- Looking back, would you say your aims from coming to existential therapy were achieved?
- How has life changed, if at all, from you having had the existential therapy?

****Note: The above were standard questions for my follow-up interviews which all participants were asked. Below are questions specific to this participant and so based upon comments in the first interview.*

Specific clarification questions / depth for 'John':

I listened to our first interview and there were some things you mentioned that I would like to explore a little bit further with you if that's ok? *(individual headings refer to original research questions*).

Beginning therapy:

- You said having a male therapist was important (because you would have been uncomfortable talking to a woman about HIV) – can you say any more about that…?
- You said you might feel judged by a woman…any more thoughts?

Expectations:

- In the first interview, you mentioned that when you came to counselling you felt isolated and alone (can you say any more about that?)
    - The therapy was 'to have someone to share how I was feeling, that was my main expectation' – that sounded important…?
    - You said you wanted 'Someone to shine a light on options for me' – do you feel that that happened? **(*note the transcript and IPA working for this is shown in Appendix vii)**
- You talked about acceptance of diagnosis as an aim of therapy – can you say any more?

Experience of the therapy:

- You talked about therapy as 'unwinding a big ball' – can you say some more? (How did this happen?)

- Spoke of the therapy being 'tailored' to you...in what way?
- 'Acknowledgement' (by the therapist) was important – can you say any more?
- '(the therapy) brought in dialogue' and 'reminded me that well maybe you can make some changes, maybe you do in fact have options' - can you say more?

Time-limited aspect:

- You spoke about having some feelings re 'it wasn't my choice for it to end' –can you say more about those feelings?
    - '*this is a relationship…that is ending in a way that I didn't want it to end and I quite enjoyed and looked forward to and now I won't have (it)*
- You also said that it being time-limited allowed you to focus – can you say any more?
- *'I suppose I was surprised about the quick turnaround…I quite quickly kind of started getting more happy again...and positive again, and felt much healthier and that probably happened in the first four to five week's …*Can you say some more about this?

Outcome:

- You said one of the things you learned from the therapy is that sometimes things cannot be fixed...sometimes there is not a solution – can you say more about that?
- You spoke of experiencing waves of anxiety around the diagnosis and that the therapy alleviated a lot of this – how did it do that?
- You also mentioned you had achieved *'a real self-acceptance'* – any more / is that still the case would you say?
- Can you say more about this being an '*ongoing process*' for you?

APPENDIX vii: IPA analysis example extract for John's FU interview

Emergent Themes	Who	Verbatim	Descriptive/linguistic	Interpretative
	NL89	You said last time that you 'wanted someone to shine a light on options' and I wonder if you could say some more about that?		
Cllr unpacked options	P89	I wanted things opened-up. I wanted to know...I felt I was completely backed into a corner and I didn't see any way out. I really didn't, and I was torturing myself and I needed that and I think I got that.	He wanted things unpacked, he felt trapped and saw no escape route for him – and he was putting himself through much pain so he needed a sense of someone shining a light on options for him	He was in the dark, in trauma, in a state of distress – so <u>he wanted and got</u> someone calmly offering a means of introducing options, allowing him to see that there are some
	NL90	Did you?		
Cllg gain = Learning to be authentic with others / express feelings to others **Not internalising / 'fixing'** **empowering and enabling** **anxiety alleviating**	P90	Yes. To realise that I was limiting myself by not actually saying things to people. Like in relationships not saying how I was feeling now, but building it all up in my head until I found a solution or some idea, but instead learning to say 'actually I'm feeling really annoyed right now, I don't know why'. Just immediately removes that feeling, that anxiety, because I am being honest with the person, I am being genuine. 'I'm irritated...I'm annoyed', just to say that.	Which he considers he got (a shone light). In the cllg there was a realisation that the was inhibiting himself by not being real with people about his feelings – he would bottle-up emotions he was feeling about the other and learned in cllg to be able to tell the other how he was feeling. By learning to do this, he found the anxiety around holding it all in is instantly alleviated from simply being honest / authentic (Very energised speaking, strong voice)	Another key outcome is that there was an engagement with what it means to be authentic with self and others – to be true to self by being true about own feelings, not stifling these for fear of upsetting the other – eliminates anxiety, empowering and enabling gain
	NL91	Yes		
MAJOR GAIN!	P91	It was quite huge for me cos i just did not know how to do that. My family don't do that.	This was a major realisation/learning experience for him – he did not grow up in an environment where feelings are expressed	
	NL92	So learning to express how you are feeling, that takes you out of that corner...?		
Liberating effect of disclosing feelings	P92	Yes, cos I suppose it brings me into the room, brings me into the present, with that person… *really* with them.	By being able to be authentic with the other person in a way frees him from the sense of	To be truthful about one's feelings freed him from a sense of (self-imposed) imprisonment

(Meaningful relating)		Rather than going 'oh yeah I'm fine'	being trapped – he is being truthful about his feelings ('mocking'(?) tone – '*oh yeah I'm fine*'	
	NL93	Yes…makes sense…I can really hear why this was so significant for you from the therapy		
Cllr style – challenging/ specific question re options **Cllr's pragmatic questions welcomed** **Specific and pragmatic questioning conveyed acknowledgement and understanding …normalising**	P93	Yes and it was useful to be challenged by options, you know, 'well why are you not doing that?' 'Why are you not moving flat?' I *can* get another job. And I think also there was the acknowledgement of 'yeah no wonder you're going a bit crazy!' when every hour of your life you are not happy with what it is like – job, house – to have someone reflect that back to me was very powerful...	He found it useful in the cllg to be challenged head-on about options – the cllr would ask him specific questions around them. By addressing each of the aspects of his life that he was unhappy with (all of it) there was a sense of acknowledgement that it was normal/unsurprising he was so unhappy – this was very effective reflection from the cllr	The cllr asked specific questions re options which he found to be challenging but welcomed as since in a very pragmatic way each problem area of his life was being attended to – so this communicated to him an acknowledgement that he needed support / that they were problems worthy of attention and his responses to life events were understood, normalised
	NL94	Powerful…		
Major gain = I have agency and I can change my life	P94	Yeah...cos it was like 'hang on, why am I doing things that make me so unhappy? I don't need to go on with this like this' Whereas before it was 'this is hell but I need to just soldier on'	It caused him to stop and question why he was soldiering on regardless doing things that blatantly made him unhappy rather than realising his life does not need to be this way ***KEY CLLG GAIN***	A fundamental realisation in cllg – to realise that life does not have to be this way – I have agency, I can change it!
	NL95	So that in itself...		
Cllg gain = acceptable to be authentic re feelings **Cllg gain = Empowerment – respecting own needs**	P95	*interrupts* I think I don't always change, I accept it as it is, I won't actually leave or say how I feel and I learned that it is ok to say that and not be afraid of telling that...not being afraid of the impact or at least not letting that stop me. They may or may not judge me, but my opinion counts too. Rather than being an observer in a way.	He has a tendency to accept things as they are rather than adapt or be honest about how he is feeling – this is what he learned, that it is acceptable to do that. While he may be judged the important thing is that his opinion matters also – not subservient / observer – centre stage!	Learned – it is ok to be honest about feelings – to not simply tolerate the status quo. Something about empowerment again, not being subservient to the other...respecting own feelings enough to attend to them
	NL96	Yes		

Cllg key cllr facilitators = conveyed acceptance and acknowledgement of pain	P96	Yeah it was really powerful cos I felt I was moaning but to have it accepted that yeah that must be tough for you, I get it...was very important	This was a very powerful experience in the cllg – acceptance and acknowledgement of how tough his life was	much for John in cllg was about acceptance – this and acknowledgement of his crisis seem to have been huge for him
	NL97	Yes. Having it accepted…and what's that like I wonder…sitting there with all these feelings you've been describing?		
To be understood and heard – reduced isolation **Cllr - Understood, normalised, reduced self-criticism and punitive judgment of self (guilt, shame?)** **Therapy as release – heard his cry for help**	P97	Well it felt that he got me and that I wasn't the only person that thinks that way, and I could make that link and I see it in other people all the time. So it took me away from feeling so isolated, I wasn't...other people get me, they get me. It removes the judgement that I placed in a way. Cos I was thinking 'I should know better than this' or 'why am I not changing this?' and kind of going 'well you can, maybe not right now, but give yourself a break!' So dealing with a job I hate, a flat I hate and HIV...wanting to scream at the top of my voice 'I am sinking!' *motions shouting, hands in air* There was no release for me before the counselling.	He felt that the cllr understood him, and that he was not alone in how he thought – now he can see commonalities with other people constantly. So the cllg with this cllr shifted him from a sense of isolation – he now was in a place of feeling that others understood him. He came with a sense of feeling he should have not allowed this to happen, he felt overwhelmed with the pressures of life – job, abode and the diagnosis all bearing down on him and he had a sense of not coping – until the cllg.	Feeling understood / normalised again > removed sense of intense isolation – someone got him and got <u>it</u>! He had become aware of the critical judgment he was making of himself re HIV and an overwhelming sense that he was not coping with all aspects of his life – cllg changed this perception Heard his cry Thought: (cllr heard him and did not reject him?) – modelling / this helped alleviate his own judgment on self (guilt/shame)

Appendix viii: Full interview transcript

Detailed below is the full transcript from the first interview with 'Michael'. As has been ensured throughout this research, this participant's real identity has been protected.

I highlight in bold within the transcript the questions which directly relate to the scripted interview schedule. However, as with all interviews conducted and reflective of semi-structured interviewing generally, where the participant appeared to be already addressing an area that I sought to address, minimal prompting was used. Equally, where it was felt some further prompting was required to help contextualise or better explain a question for the participant, this was also done. As such, the order in which specific questions were asked in relation to the interview script may at times be different from the Interview Questions Schedule (see *Appendix v*).

Who	**Transcript**
NL1	*Introductions and introducing format etc* Can I just start if you could say your age and ethnic origin?
P1	OK...oh gosh how old am I?! Erm 36 and White British Scottish.
NL2	I thought I heard the accent...how long have you been down here?
P2	17 years *laughs*
NL3	OK so that's why it's so soft...
P3	Kind of yeah but I went to drama school and I had elocution lessons and they kinda drummed it out and also I'm from the north east (of Scotland) so nobody understood a word I said *laughs* so the kinda drummed it out of me. And you?
NL4	Well I've been down here 9 years, and folk still don't understand me! *laughs* OK so just to reiterate the purpose of the research is that I am trying to explore the subjective experience of users of the counselling service specifically whose counsellor is an existential therapist – how that works, what comes up in the weeks and indeed does the 12 weeks that HCS offers, is it enough, too much, that sort of thing.
P4	Oh yeah
NL5	So that's a summary of the purpose but please if you have any questions as we go through it, don't hesitate
P5	Ok great
NL6	**OK, so I know that you ended your counselling a few days ago, and you had 12 sessions?**
P6	12 sessions yes.
NL7	And was this your first experience of therapy?
P7	No, I underwent some counselling back in 2004 just after my HIV diagnosis. That was laid on by the clinic that I attend. That was with a health adviser but that was only 6 weeks of sessions but I ended-up with 2 lots of 6 sessions. That was a pretty rough time for me back then, my dad had just died and also the diagnosis coming along...so...
NL8	Yes, sounds very rough. *pause* And so that was 6 years ago *nods* so there has been a 6 year gap until this recent counselling...

P8	Yeah
NL9	**Before we go into more detail, can you remember what sort of things were explained to you or what you were offered at assessment?**
P9	Erm...not...well...oh gosh i'm trying to remember...erm it was that she just wanted it to be a kind of safe space, like somewhere to free-flow type thing but she didn't go into too much technicality around what she would be doing, that sort of thing. And that was fine, that pretty much was what I was after so...yeah
NL10	Ok did she talk about her approach specifically, or was it more around explaining that this was a safe space...?
P10	Yeah that was how she approached it, safe space.
NL11	OK and was that important to you?
P11	Erm...well a friend of mine had sort of told me about CBT and erm and thought I might benefit from that but that aside, no not really.
NL12	Did they say to you why they thought CBT would benefit you?
P12	Yeah cos it's funny cos it came up in the sessions as well! It seems to be a kind of repeat pattern that seems to keep happening, so *pause*
NL13	*pause* and CBT being something that deals with repeat patterns…
P13	Yes, yeah that's how I understood it.
NL14	**OK, now can you tell me something about what brought you to counselling this time?**
P14	Yeah I kind of underwent a sort of minor breakdown, as it were. Erm at work as well I was under quite a lot of stress and pressure, cos I used to work at the *work location* and I was solely responsible for the closure for all of that and stuff and I just felt under a lot of pressure around that as we moved *to another work location* and erm there was a relationship break-up and it was just horrible, nasty time for me.
NL15	A long-term relationship?
P15	Actually no, not that long-term but it kind of had quite a huge impact on me, so...and that was in the beginning that was, I would say for the first 4 sessions, that was the focus, definitely and it's still there now, so I don't think it has been resolved but it's getting easier
NL16	Can you say more?
P16	Erm in terms of having a breakdown type thing, you know what I mean?
NL17	From pressure building...?
P17	It can be, it doesn't have to be about work and or it's a relationship break-up, I don't seem to have any luck with that and I tend to take everything personally and sort of like blaming myself in a way and I seem to go into a self-destruct kind of mode, drinking that sort of thing
NL18	And so you came along to counselling at HCS with a view to...so these 2 things had coincided, the pressure at work all this change going on and the relationship ending...
P18	Yeah it was mainly the relationship really, it just got in the way of everything and I just sort of lost focus when it came to work and it all kind of...once the move was complete, I had nothing to take my mind off the relationship and the fact that it had ended and the nature of the way it had ended and I just hit rock bottom it was like slap bang just hit me full force.
NL19	And what was that like, hitting rock bottom…?
P19	Well I never missed work, erm and erm that sort of overwhelming feeling of not wanting to get out of bed in the morning, not wanting to wake-up and just sort of overdrive really, sort of like auto-pilot. All I did was like come to work, do my work, and go home and that was it. It just seemed that there was this massive void. That seems to happen quite a lot *laughs*
NL20	So this time, what happened this time that took you to counselling? Was it particularly intense this time...?
P20	Yeah yeah.

NL21	**OK *pause* and what were your expectations from coming, what did you hope to get from the counselling?**
P21	*clears throat* I was hoping to get answers and I was hoping that *cllr* would sort of I don't know maybe magic some sort of routine up for me *smiles* you know what I mean? I think I expected *laughs* way too much and that was kind of frustrating for me I think I was looking to her to give me answers like a teacher type role, telling me to do stuff. Cos I realise that part of it (11:28 approx) is myself erm kind of like avoiding change as it were or not having the motivation to take on board change or allowing patterns to...you know what I mean?
NL22	Yes
P22	So more for her to I don't know take me by the hand *laughs*...
NL23	So maybe looking for quite directive,
P23	Yeah yeah
NL24	...you said teacher role…
P24	Yes
NL25	...take me by the hand...
P25	*interrupts* 'this is how you do it...this is what you should be doing...do it!' *slaps hands* basically. Yeah and I found that quite frustrating, I would end up not arguing with her but saying to myself 'aargh why am I expecting too much?!'
NL26	Too much?
P26	Yeah.
NL27	OK, so you come along expecting from your counsellor some…guidance?
P27	Yes
NL28	Structure?
P28	Yes
NL29	And did you feel you were getting that? You said you felt quite frustrated...
P29	Erm...yeah...erm...I dunno, she was letting me sort of like find the answers for myself and I kinda knew the answers anyway but there wasn't I dunno *pause* She did…she did give me some but with my lack of motivation I just didn't do it initially, which is kind of a shame in a way.
NL30	Say more…?
P30	I…I knew that I needed something to happen because, this time especially, because it had happened before erm so this time I felt ready before the sessions had even started, so I felt…ready.
NL31	To explore...?
P31	Yeah I approached *service manager*
NL32	Did you? *nods*
P32	And also the doctor, I went to the doctor and he recommended that I seek-out a counsellor
NL33	Ah so you also went to your doctor...
P33	Yeah
NL34	Did he/she recommend or prescribe anything else?
P34	No he/she knew it was counselling I preferred to meds…
NL35	OK so expectations in a general sense you were looking for quite a directive 'this is what you need to be doing' *nods* but in what you hoped to get out of it, am I hearing you wanted to look at this repeating pattern?
P35	Hmm and find ways of stopping it or avoiding it or if it does happen again finding ways to suppress it or...I don't know
NL36	Ok so in the sense of that void you talked of, erm, going to sleep and not wanting to wake-up because when you wake...?

P36	The problems are still there and I'm the same person. When I am asleep I'm not really thinking or doing anything so…
NL37	It's like escaping?
P37	Yeah
NL38	So when you actually…how long did you have to wait to see *therapist*?
P38	Not long at all.
NL39	So would that mean the crisis you describe that prompted you to seek counselling, were you still in the midst of it?
P39	Still in the midst of it definitely. Like I said I still have my moments especially at weekends, where I tend to lock myself away. I've only just started, through *therapist* actually, taking myself out. So recognising the signs of wanting to stay in, to resist that and take myself out. But it's...you know...only like a few times...I still have a tendency to shut myself away.
NL40	Hmm. So shutting yourself away because socialising or being about is too…?
P40	Just don't wanna do it.
NL41	OK. How did things change then?
P41	She was just, you know, offering well here is a suggestion...cos I've got this thing about being in public places on my own, I don't like it and erm that's kind of I don't know through what has happened recently...the breakdown for want of a better phrase, it has seemed to be more overwhelming than it has been in the past. (18:27) erm so yeah but erm with *cllr*, through encouragement I suppose through *cllr* I managed to have a coffee on my own which was a big step
NL42	And how did that go?
P42	It was horrible
NL43	What happened?
P43	It was awful. I just thought everyone was looking at me, everyone was laughing, just awful paranoia. I don't think i've ever drank a coffee so quick in my life, just gulped it down...yeah
NL44	Have you done it again or was that...
P44	Not really no, if I arrange to meet someone I hate being early. I'll arrange to make myself late so I know they are there and if I'm approaching a bar or restaurant or cafe, I'll phone them and say 'are you there or not?' cos I can't even bear walking in the door to stick my head in and look.
NL45	I'm just thinking when you called here tonight...was that from that same place of not wanting to come if I wasn't here yet?
P45	Yes yes
NL46	So it's like a coping mechanism of some sort?
P46	Yeah yeah
NL47	So *cllr* suggestion, quite a direct suggestion in fact?
P47	Yeah.
NL48	***pause* OK so what would you say were the major themes that came up?**
P48	Erm my lack of self-esteem, erm really poor self-image, a lot of guilt issues, *pause* and issues around assertiveness, those were the main themes
NL49	Can you say a bit more in terms of those?
P49	Well the lack of self-esteem and poor self-image comes from way way back when I was a kid. Erm so that's kinda ingrained in me really..
NL50	From family?
P50	Family, school, teachers.
NL51	Teachers?

P51	Yeah. Erm to the point now where I can't even bear have a mirror in my house. I can't abide my own reflection, I hate photographs of me, that kind of thing. Erm and in terms of assertiveness that goes with relationships be it work...friendships...erm I ...I...tend to have difficulty in saying no *smiles*
NL52	Do you?
P52	Yes. So...yeah. *pause*
NL53	So that would have been quite difficult stuff to be looking at...
P53	Kind of, we...yeah. Yeah yeah. Didn't really go into too much detail as in going to childhood stuff, it was more current stuff, we didn't really go back to the history of it
NL54	And did that suit you, or would you have liked to have gone into the history?
P54	*sucks teeth* don't know, I'm kind of the impression like 'what's happened has happened you know? It's what's happening now really that's the important stuff. It's all very well going back to the childhood but really but what does that solve? So...
NL55	And it sounds like you already have an awareness already of the sources of these issues...
P55	Yeah
NL56	So it sounds like you had already thought about it significantly yourself?
P56	Yeah, well yeah.
NL57	So self-esteem, assertiveness, finding it difficult to say no to people *nods*. And I can imagine, in your work setting, as an administrator, people must be turning to you all the time...
P57	But I kind of still get the impression that you know 'oh i'm *just* the administrator'
NL58	You said that tonight...'just an administrator'
P58	Did I...yeah?
NL59	And my impression, as I'm sure with a lot of people, is that it's quite pivotal to your area's function…
P59	Really? I don't get that at all. Seriously I don't, I think I am easily dispensable. I mean get a volunteer in to do it *laughs* you know what I mean?! That's how I see it, anyone can do it, do it blindfold. Whereas it's only recently, you know (his manager) has become aware of this, you know as soon as she took over as (25:04) manager of the team, she was aware of it. Especially at (satellite venue), cos I started out there as a receptionist and I was left on my own downstairs, so I was on my own for eight hours every day! *laughs* no communication with anyone and erm and she was aware of that so she, thanks, thanks to her she has like included me in team meetings and things and training that the team would do, she includes me more now
NL60	And that feels good?
P60	Yeah it does, I do feel part of a team now.
NL61	Good. *pause* yeah cos I'm just thinking…having these slumps where you are wanting to walk away and just be by yourself but at the same time enjoying to be part of something in terms of the workplace...
P61	Yeah at the moment and I think if it hadn't been for work, in fact I'd say for the majority of this year, if it hadn't been for work, I'd have probably have done away with myself. Seriously. And just about that time, just before counselling started, I was encouraged through HR and occupational health to take time off and that was horrible. You know, you know as much as people would enjoy not being at work, to me, while it was nice not having to think about work, but it was a kind of double-edged sword – having too much time on my hands to think about an contemplate ree-ally horrible stuff that i was sort of like drudging up on my own, you know without anyone's help to do this, so it was such a relief to get back to work.
NL62	Too much thinking time?

P62	Yeah it's horrible. And safe to say in that two weeks all I did was sleep...basically *laughs* not wanting to get up so it was basically like wasted time
NL63	Yes
P63	And I hate that idea. Wasting time, you know what I mean?
NL64	Do you? *he nods*, so you like to be quite productive with your time, or at least to...
P64	*interrupts* yeah I do, I don't know, I just hate the idea that time is ticking-by and all I want to do is sleep.
NL65	Have you always been like that about wasting time?
P65	More so now, you know as *laughs* I'm fastly approaching forty I'm like *Scream pose* 'aargh oh my god' *laughs*
NL66	*laughs* one of the curses that comes with age...
P66	Yeah erm so yeah that's probably a recent thing. *clears throat...pause*
NL67	Erm, but a word that has just come into my head, and it's my word, so throw it out if it doesn't sit well but I was just thinking when you were describing sitting down on the ground floor at the reception alone for 8 hours, no interaction and then this sort of semi-enforced time off work, not enforced but encouraged, where you are sitting alone at home...sounds lonely?
P67	Hmm *nods* yeah and I keep thinking although I have this huge group of friends...well not huge...but I felt so lonely and absolutely desperate and sad and all of those things and *pause* but again not having the ability or not realising that all I had to do was pick up the phone and one of them would have been there or you know I could have gone and met them or you know what I mean? I didn't have that in me or some reason. And that's what it got like at weekends as well (30:00) sometimes I don't know it just seemed to hit me, there is an inability to...to recognise what is going on and that all I need to do is just phone or text somebody or just get my backside off the couch and go outside *laughs*
NL68	And if you did, like you said recently, once you are there with your friends was it ok or were you thinking 'I want to get away'?
P68	Erm...erm...
NL69	I mean was it more the thought of going out or was it...
P69	*interrupts* yeah more of the thought I think, yeah,
NL70	So once you were there...
P70	It's a mixed bag really. There have been times when I've been out and I'm thinking 'God I'd sooner just veg out on the sofa and be home, I can't wait to get home' or I find it mentally a chore to be with my friends and that's an awful thing to say but I'll be thinking 'go—od here we go again, the same old bloody stuff' you know what I mean? And I know that's an awful *awful* thing to say but that's how...*looks to ceiling* pause*
NL71	How you felt…
P71	Yeah
NL72	Say more?
P72	Yeah, hmmm, doesn't happen all the time but it does happen sometimes when I am feeling *sigh* how can I put it? It's just sort of like mono *laughs* is the only thing I can use, sort of like grey...nothing...it's an existence...erm which I get quite a lot and I feel oh I don't know I cant abide being with people and I hate being alone...it's I suppose it's just an uncomfortableness of being where I am at. And not happy with where I am at. Annoyed at myself for allowing me to become like this. Or not having achieved whatever I set-out...whatever the plan that I had when I was younger was and I just kind of got here and I'm like 'hmm yeah ok' *rolls eyes*
NL73	Hmm

P73	…don't know if it's achievable now. But it's just that recognition of myself at a younger age and how ambitious and active I was and this sort of hunger and greed for wanting to achieve what I want and now I'm like 'hmm yeah ok...nothing much is happening'
NL74	I understand. And just thinking about what else you said in terms of coming to the counselling - relationships...you were saying erm…
P74	I don't seem to be able to keep them. I don't know if it's me getting bored or...I don't know, I really don't know. They don't seem to last anyway *pause*
NL75	And you want them to?
P75	*interrupts* yeah. Yeah. It's quite important for me but I find that I am seeking it but not getting it
NL76	So it was high on the agenda for counselling?
P76	Oh yeah for sure
NL77	How you feeling? OK to continue?
P77	Fine thank you, yeah yeah happy to continue
NL78	**So these were all things that came up in the counselling?**
P78	Yeah
NL79	What was that like?
P79	It was quite erm there was a couple of sessions where I kind of hit mono basically and wasn't responsive. Constantly looking at the clock and wanting it to be over, I literally had nothing to say, not interested and it wasn't, there was nothing she could have said or done I was just not interested. There was only a couple of sessions like that but normally...normally it was quite vibrant, for the first time we kind of bounced off each other erm so conversation and it...for some reason it was fun *laughs* I enjoyed predominantly the sessions! I liked her...I felt a connection
NL80	Did you?
P80	…yes, personally with her so...*pause*
NL81	You said you enjoyed the sessions…
P81	Yeah. To begin with I was a bit dubious that I was getting a woman, actually.
NL82	**Were you? Were you offered..**
P82	No no no no. Oh hang on yeah 'is there a preference?' and I said 'no, no not all' but when *manager* said 'we'll give you a lovely woman' and I was like 'oh ok!'
NL83	And what was that about?
P83	I don't know, I don't know. I have no idea. I think maybe because of the...it sounds absolutely ludicrous and ridiculous...no I don't know, I honestly don't know *pause* I've no idea
NL84	Hmm I just wonder when you say you felt a bit dubious
P84	Well…yeah I did feel pretty dubious at first
NL85	Can you remember what you were dubious about?
P85	Hmm, god… *laughs*
NL86	*smiling* What you thinking?
P86	Wow this is interesting
NL87	Is it…
P87	Yeah. I was dubious. But I'm glad I didn't say anything because I don't think I could have got a better person I think who got where I was coming from
NL88	If I could just ask a bit more about those initial thoughts around not wanting a woman
P88	Yeah
NL89	What was it about her being a woman?

P89	I think because my relationship was with a man, that was sort of like high on the agenda at the time and it was through exploring the relationship and what actually happened that the issues came up, the themes
NL90	So it could be thinking 'if she is a woman…
P90	*interrupts* Yes. Yeah she won't get it.
NL91	OK I understand.
P91	Erm the girlfriends that I have are strong strong characters *smiles* that are domineering erm which a few of my male friends really have serious bugbears and issues. They tend to control a lot of my life. Like for example, my mother is the main one who is quite dominant and will not leave me alone. Erm my friends as well are quite really overbearing characters which is kind of interesting *laughs*
NL92	hmm…
P92	*interrupts* I don't know. I love my friends dearly but it kind of irritates me that they want to control me and I kind of feel stifled in a sense erm like I have got one of them staying with me at the moment and it's an absolute nightmare. I live in a tiny studio flat and we are literally living on top of each other and oh the situation is just getting out of hand and I feel that I am actually going to lose her as a friend because I do I feel stifled and strangled. So...
NL93	That sounds really diffciult…
P93	Erm...oh god yes, she will not allow me to talk for myself. Ever! This is typical of my female friends.
NL94	What they will talk for you on your behalf?
P94	Yeah they will quite openly and blatantly do it. Erm...
NL95	So if you are in company...?
P95	Erm the friend in question that's staying with me at the moment, erm I recently had some time off some annual leave and it's a perfect example of it. And erm we were out with her sister and her sister's husband in Chester and friends of theirs and erm the female friend asked me what I did and Lisa just went in and 'blah blah blah' just told everybody what I did and I just sat there and thought 'well actually you've got that bit wrong' and they were all asking me questions about sort of HIV and what *company* did and she just bulldozed right in *laughs* and just spoke for me! And I was like 'hang on a minute' *laughs* you know what I mean?! 'they are asking me what I do, not you...wind your neck in!' But I don't have…*pause*
NL96	Would you say that?
P96	No. In my head yeah but I would never ever say that.
NL97	Because?
P97	I don't know. Because I'm scared to. Because I'm scared that we will end-up losing a friendsh...I don't know *pause*
NL98	Scared of losing…?
P98	Oh but the times that I actually have stood up to her, and it's always happens with a few of my female friends, it's 'oh stop being a baby and stop being so bloody precious', that's *always* what they say, their excuse for ME taking the initiative and standing up for myself, I'm always told to stop being so precious and ridiculous (43:21) or 'you're so gay!' and I'm like 'ok!'. Feel a bit bullied.
NL99	Really? *he nods* Sounds it…
P99	I think it is. I think it's more controlling than bullying to be honest.
NL100	OK, controlling…
P100	Yeah and another friend of mine it was always an attack on intelligence and me being a complete and utter retard for want of a better word and I know it's so politically NOT correct

	but you know things like that she would throw at me, like 'oh you're such an airhead' and that's exactly what teachers used to do with me in school, as well. Not so much in the secondary school but particularly in the primary school and that's kind of repeated. A lot. And I do have sort of self esteem issues with regards my intelligence hence why is say 'i'm *only* an administrator' you know what I mean? I haven't achieved *anything* at all and I'm 36. So...so...yeah.
NL101	(45:08) yes, and it sounded like you how you have drawn a link of some sort with how teachers used to be with you and your experience as an adult
P101	*interrupts, smiling* female friendships that do exactly the same.
NL102	Exactly the same…?
P102	Hmm *nods* yeah *laughs* erm I don't know, I don't know what to say about that really
NL103	Ok well maybe this will come up more as we talk
P103	Yeah yeah sure
NL104	**And this come all up with *cllr*?**
P104	Yeah yeah it did and how people, how I allow people to sort of speak to me and how I kind of allow the kind of behaviour that I allow towards me, came up
NL105	Principally by women?
P105	Well not just by women, by male friends as well. Couple of male friends that I have that are quite controlling but it became clear it is predominantly female, all my female friends are very strong characters and do tend to take over
NL106	Just before we go on, I'm thinking about when you are told that you have a female counsellor, how you might...
P106	*interrupts* Oh yeah but that was what I was seeking! I was looking for her to tell me what to do! *pause* Hmm and through her not doing that, maybe that's where I'm coming from with the rapport and enjoying the sessions
NL107	Can you say m...
P107	*interrupts* a different kind of relationship with a woman
NL108	Ah, I see. So you enjoyed the sessions with a woman not telling you what to do..?
P108	Yeah. Yeah. Yeah absolutely actually! *laughs* *pause*
NL109	And you also said it was quite frustrating?
P109	Hmm *pause* *nods* it's only now, in hindsight looking back to the sessions, that I did find it…feel frustration not just at myself but maybe at her as well
NL110	Say a bit more if you can...
P110	Erm it was just her...her easy attitude, you know what I mean whereas I wanted a dictator to give me the answers, to show me the answers and she was like 'no, you need to come up with the answers yourself' *pause*
NL111	Yes makes sense
P111	Yeah!
NL112	So you find yourself with a counsellor who is not giving you answers
P112	Yeah hmm interesting I wonder what would have happened if I had!
NL113	Do you think with *cllr* taking that approach, of being like 'no you have to find the answers yourself'…I'm thinking it sounds like she was being more facilitating of your work, does that sound…
P113	*interrupts* yeah that sounds right
NL114	Do you think that was a useful approach for you?
P114	In hindsight now yes I do. When I was going through it I'm not so sure.
NL115	What do you mean?

P115	I did *pause* I can see, I can see the whole picture now and how knowing how I have come out the other side you know rather than being in the process. Yeah because yeah she has helped me now even. I'm seeing that talking about it
NL116	Is that becoming apparent from this conversation
P116	Yes. Yes all of it has. Because when I was going through it I was and my attitude when it ended I was thinking 'well that was a waste of time I don't think I have learned anything' but now talking to you tonight *laughs* I now realise that actually no a lot of good did come out of those sessions and that actually she was teaching me to think for myself. At the time because maybe because I was going through it, I didn't realise what was going on, or I was too caught-up in all the negative stuff
NL117	Hmmm so while you are sitting thinking about that just now, is this quite a realisation for you *M nods, smiles* when you say 'actually now I think about it, a lot of good came out of that' erm can you say more?
P117	I don't know...in terms of..?
NL118	In the sense of 'she got me thinking for myself'...
P118	Yeah she has and like I began to go into briefly was realising a negative situation when I am in it, like wanting to be alone, there are times now where I do muster up the energy and I do go out even if it is just for a short while and erm and another practical one was we talked about was my inability to actually finish a book and erm at the beginning at the counselling – here you go she did give me something to do *laughs* she said do you have a book in mind, I want you to begin it...and I am still plodding along with the same book but I am determined to finish it and that would be the first book since a long long time that I've whereas before I would just read the first chapter and get bored, give up and never go back to it.
NL119	So being able to maintain your focus and concentration on something
P119	Yeah
NL120	Where are you at with it?
P120	*smiles* Oh god I've got a long way to go, I'm at I'd say not even the third of the way through it
NL121	But past the first chapter?
P121	Yeah.
NL122	So actually a couple of quite direct suggestions from *cllr*?
P122	But it wasn't...oh it wasn't...oh...it all came about, her not actually doing that though. She wasn't directive in that way, it was, I don't know I can't remember how she approached it, I mean it was along the lines of maybe a suggestion...?
NL123	So quite tentative?
P123	Yeah rather than 'you will do this'!
NL124	And that worked for you?
P124	Yeah but again this is in hindsight. It's me thinking back and going 'oh actually...yeah!'
NL125	Hindsight…
P125	Hmmm *smiles*
NL126	*smiles* Can be a wonderful thing
P126	Totally *laughs*
NL127	But that sounds important…to leave thinking 'not sure what happened there'…but then looking back now, here
P127	*laughs* Yes and in fact I left thinking not sure if I'm any further on when actually I am, or a big step further than I was so...yes absolutely.
NL128	**OK erm can you give some specific thought to what actually worked for you, what suited you?**

P128	I would say, I would say her...stands out first and foremost.
NL129	**Her..?**
P129	Her personality, her manner, her warmth, her presence, she's very friendly, friendly person so out of everything it was *cllr* herself.
N130	What did you like about her personality?
P130	She was quite down to earth and her ability to relate to what I was saying and what I was feeling and what I was going through, and sometimes she drew on personal experience as well. Not all the time but I think where she saw it as appropriate she would draw on her experiences.
NL131	Can you give an example at all?
P131	*sucks teeth, deep breath* My motivation, and erm wanting to join the gym but *laughing* not actually going through with it *laughing*
NL132	Like 'you're not alone there'…
P132	*laughs* Yeah
NL133	What would *cllr* say?
P133	How she you know has gone online and almost bought the sort of buttock-cruncher machine you know what I mean, and she said it's just gathering dust as a clothes horse or under the bed *laughs*
NL134	Ok
P134	And about the relationships as well.
NL135	What would she say about that?
P135	Erm *pause* just you know past relationships or past experiences she's had
NL136	Hmmm
P136	Or she, I don't know, it was mainly on the nature of the way that I was let go, or dumped for want of a better word.
NL137	So cllr would offer...?
P137	Cllr would offer...'well this sort of happened to me...' erm *pause*
NL138	So 'when I have been dumped'...?
P138	Yeah not that the situation is the same but similar
NL139	OK, what was that like, getting some personal disclosure like that from your counsellor?
P139	Good. It built the trust.
NL140	Did it?
P140	*nods* Hmmm
NL141	It sounds like you got on well
P141	Yes, absolutely we did
NL142	What was that like?
P142	It made it easier, very much so. More human.
NL143	**OK now what was not useful? What would you say, 'actually that did not really work for me'?**
P143	*long pause* Erm I suppose...like I am glad this has happened, because it has kind of crystallised the whole process but had you not been doing this study I would not have had that so that's the only thing that sticks out in my mind is the finishing of it and you are just left to get on with your life and it's not... and it is that uncertainty, you know 'what the hell just happened *laughs* for twelve weeks?!' 'What have I actually achieved if anything, what have I actually covered? Have I covered this, have I done this?!'
NL144	**And was there anything like that...about recognising you were approaching the end?**
P144	No there wasn't...well kind of...it was like 'well what has changed?' and I basically said 'well nothing, I still feel the same person, I still feel the same way as I did when I started' so it was

	kind of, it was an anti-climax. (1:02) to be honest...I was expecting some sort of miraculous thing! Again expectations, maybe my expectations were too high but you know 'well ok it's finished now and it's over...see ye!'
NL145	Hmm and 'what was that?'...
P145	Yes
NL146	So there wasn't a clear appraisal at the end?
P146	Yeah yeah the ending was very disappointing. For me.
NL147	Can you say more? What was disappointing about it?
P147	Like as I say, it was an anti-climax for me, just like 'ok that's it...oh ok fine!' erm but again I don't know if my expectations are too high, maybe it should be like that...erm but yeah without, if you hadn't been doing this...*pause*
NL148	This has been useful for you?
P148	Yeah!
NL149	Is there anything from the counselling experience that surprised you?
P149	Not really no.
NL150	Nothing sort of stood out as 'oh I didn't expect that'?
P150	No not really, I think it was as I expected
NL151	OK
P151	...apart from the end which was you know what I mean was not satisfying I kind of felt 'hmmm ok'
NL152	OK now just to recap a little, I am hearing that what brought you to counselling was this sense of malaise, or breakdown *he nods* and you haven't mentioned your HIV diagnosis…
P152	*interrupts* 6 years ago it was the predominant focus
NL153	OK
P153	Hmm along with the bereavement
NL154	I see. Erm and how are you now? How's your health?
P154	Good. It's fine all under control and I'm on a regimen that really suits me, no bad side effects and the little side effects I do have I manage to fit into everyday life so it's good yeah
NL155	That's good news.
P155	*interrupts* but at the time, it was a bad period, receiving the +ve diagnosis and it just seemed a catastrophic chain of events following the diagnosis set in. Because it was a late diagnosis as well which is why, yeah all kinds of stuff...KS developing quite badly on my face (1:06:27) and stuff and having to undergo chemotherapy but I was too ill for the to start the treatment on the KS so they had to wait for my CD4 count to go up so the KS was actually getting worse and I was getting sicker and sicker so they decided to start the chemotherapy and I was so ill so I was hospitalised following the chemotherapy, erm the regimen they put me on...AZT...made me anaemic and my kidneys started failing so it was like *laughs 'oh god!' so it was like a pretty tough time
NL156	Gosh it sounds it...and the counselling you got then, did that come after all that or was it straight on...
P156	*interrupts* erm it was kind of a mixed bag really, as I was going through I think I was going but I had to stop and then I think I went back to it for another six sessions but that was it really.
NL157	Did the HIV and your health come into the work at all with current cllr?
P157	*shakes head* Not the diagnosis as such, that was a while back remember...but more how I see things now
NL158	Say more...

P158	Well I had dealt with the diagnosis and all the stuff around that, illnesses all that, but now I was looking at my attitudes now I suppose
NL159	OK and what came up for you?
P159	*coughs, clears throat* Erm to begin with there was a negativity, erm I'm talking....you're faced with your own mortality basically. Erm...but now the ability...I mean that was a pretty bleak and negative time...but I can now see that how – and this will sound absolutely atrocious – but it kind of has been my saving grace! *clears throat*
NL160	Say more?
P160	Well cos my dad died before my diagnosis and I took that really badly, really badly. I mean I hit rock bottom and looking back now I can see where I was going and it was not a pretty place at all, in terms of the amount I was drinking and how much I was consuming and erm time off work purely because of that cos i wasn't able to function cos of the amount of alcohol I was consuming...*pause*
NL161	So quite a self-destructive
P161	*interrupts* very very much so, so I was on the brink of losing my job and erm and then the diagnosis happened and that was a kind of wake-up call and I kind of realise that now
NL162	Ah ok
P162	That if it hadn't been for the diagnosis I would have probably been dead anyway *laughs*
NL163	Because it made you stop and
P163	Take stock, take stock of what was actually...and take control of what was actually happening inside me. Erm what I need and more of a focus on what I need to do in order to maintain my....I am worth fighting for and I am not going to let this beat me. Know what I mean so that all came back.
NL164	Powerful stuff *nods*. You mentioned mortality, forced to face your own mortality...what's that like?
P164	Scary...quite scary, erm quite shocking and that whole... it seems it was almost a transition from child to adult as well cos it's that whole for me, that especially in your twenties you think you are invincible and nothing is going to come between you and the world and all of a sudden this comes along and it's a massive slap in the face and it's like 'actually *laughs* you're not all that! We're actually quite fragile at the end of the day and it only takes a little something *snaps fingers* and your whole world is spun on it's axis'
NL165	Yes. Erm I was just thinking when you said earlier on that you do not like wasting time...
P165	*interrupts* Possibly, yeah, that I could go any second, yeah, there probably is a link there. Having faced you know I hate to say it, but what I have been through I think that yeah, time is precious. Definitely. And maybe what I have been through with my dad as well has brought that to light.
NL166	hmm
P166	I think any time when death is brought right up to our face like that...be it losing a close relative, or illness...it can have an effect...
NL167	Yes when you talked about sailing through your twenties and then something comes...
P167	Hmm. Hits you like a brick. And knocks you out of that.
NL168	But it sounds like there is something positive that comes out of that
P168	Yes this is what I am saying – I am aware of life now. Yeah. Like I do view my HIV as a saviour for me. Absolutely. It's a positive thing.
NL169	And if that hadn't happened…
P169	Totally, I would have totally self-destructed.

NL170	Wow. And given that you have talked about some of the issues that brought you to counselling was you know being in this very negative mono place. But at the same time it sounds as though underlying there is also a drive...?
P170	Yeah yeah now yeah erm I just you know I allow the negative to cloud over a lot and I think that's probably where the CBT where I thought, or my friend thought that that might cos I am a positive person you know. I strive to be, I want to be, it's like a constant battle. Around that time it was just horrible it was the worst attack really of the negative. Given even given erm my you know my dad dying which was horrendous and then the HIV but I would say this time was really low for whatever reason if be it the break-up I would say it was worse than either of those two situations.
NL171	Hmm
P171	I can't explain that.
NL172	Where do you think you are with that now in terms of the recent...
P172	*interrupts* Well I am aware that I have low days but I am combating that, I am fighting it. Being at work, I've got some really good friends at work and I actually look forward to coming in to work erm
NL173	So the relationships you have in work
P173	Yeah it's really positive and you know there are a couple of friends I have who are HIV positive as well and I think it is being surrounded by people who have such a positive attitude to HIV – that has helped me a helluva lot. I mean it has helped me develop this attitude that you know it has been a saviour to me and actually you know I owe a lot to being HIV positive you know what I mean? There's a lot of good that has come out of that it is not all negative press!
NL174	It's good for that message to get out also isn't it? *nods* It's not often you hear that generally. Erm...I think you have pretty much talked about...oh the other thing...something that is coming up that I have been thinking is that despite this low place, this negative place, erm something spurs you on to go and seek help. You know you talk about a lack of motivation but there was a motivation that made you go and seek
P174	*interrupts* yeah it was a realisation that 'oh my god here we go again and I am fed-up and tired of feeling like this'. Erm and also if I'm not lucky you know I could end-up losing or jeopardising a really good job through this and it's just not worth it and I am not prepared to do that – that was my motivation behind it to do that
NL175	But nonetheless it takes some courage to do that.
P175	Well I think possibly what has helped is that I have, albeit it was quite a different experience, but maybe the counselling I had in the past made me realise that I needed the help and that there is no shame in going to seek it
NL176	Hmm so not quite a daunting prospect...
P176	Yeah and having been through it before and it was pretty much forced on me. I had to do it! Cos I think it was all part of the diagnosis process so yeah, so and that helped me a lot at the time cos I hadn't had any counselling over the bereavement. I hadn't had even a chance to grieve over my father at that time, cos I had so much to sort out for my mum, you know the estate, all the funeral arrangements, cos you know she was in no fit state to do it so I had to take control and then there was the fall-out for all of that and then I was up in *home* for like 6 months trying to sort it all out and then came back to London and within almost a matter of months after that I was diagnosed and it was like 'aaaarghhh. But then in that brief time between the two I was like...back down in London and it was time to be alone with my thoughts because I didn't have the focus that I had had up in *home* because I had to be strong for my mother. And family and siblings telling me that i wasn't

	allowed to grieve it just wasn't the done thing for men, i gad to be strong for my mother, I wasn't even allowed to cry in front of her,
NL177	Hmmm
P177	Erm and then as soon as I *laughs* came here (London)
NL178	It hit you
P178	Yes. Big time.
NL179	Really tough time?
P179	Hmm
NL180	And yet you still say, this recent experience is
P180	*interrupts* yes absolutely. Because yes it was a tough time, and there were major themes to have to tackle erm but it was...they happened...and almost I didn't have a chance to think about them do you know what I mean?
NL181	Yes
P181	Whereas with this one...I had the time to think about what was going on, had the time to wallow in it really and think about it. Yeah. I think that is the difference between the two situations.
NL182	Can you describe what it felt like when you did wallow as you say...? (1:21:42)
P182	Desperation. It's utter sadness, erm total lack of control over emotion and just an 'oh god', a desperate howl...it's almost like a guttural howl for help. Erm and yet everything is kind of grey, everything is almost like static, it's just a nothingness and you don't think anyone can hear what you're going through, or that anybody cares about what you are going through or how you feel. Complete isolation and not having the ability to find a way out of it.
NL183	A familiar feeling for you?
P183	Yeah when I was a teenager. Quite a lot. And funnily enough severe attacks of agoraphobia. Yeah. Scared to be in crowded places, in school and things erm
NL184	I have such a strong sense of what it was like for you. Erm you have alluded to this and my next question was going to your experience of the *cllr*...
P184	Oh very comfortable yeah.
NL185	Yes. So now what was it like to lose contact with her?
P185	*sucks teeth* Kind of sad in a way erm yeah I looked forward to, it was almost like a chat and it was quite animated, we built-up quite a rapport. And although I was in utter despair, I found myself laughing at myself - there was quite a lot of humour there as well. Which really helped me sort of 'OUT' of that pit. She allowed me to rant and rave and she seemed quite amused by my rants so it was kind of like a good audience, she likes me...I was like 'yeah...I'm looking forward to this! *laughs*
NL186	Was it important for you that your counsellor liked you?
P186	*whispers* Oh yeah
NL187	You said that with some certainty there...
P187	Definitely. Absolutely. I'm that type of person that I hate the idea that there is someone out there that hates the ground I walk on *laughs* That really irks me. So yeah but I'm not that kind of person who goes out of their way to like *have* somebody like me, do you know what I mean?
NL188	Sure
P188	I won't be like too overbearing or really upset but just if I am allowed to think about it I would get upset so yeah, it definitely helps
NL189	It helps
P189	Yes

NL190	(1:25:52) erm ok just a few questions left. **Now were you aware from the beginning that there were a set number of sessions?**
P190	*sucks teeth* Yes and no. From the beginning, ah from the beginning yes...cos *assessment manager* had talked me through it. But when you are going through it though you don't want it to end and that's a big major thing I think. For me it was.
NL191	What do you mean...'a big major thing'?
P191	Erm this kind of like, oh this one oh no that's another one gone, so that's just nine left, oh now just seven left...
NL192	So you were keeping a sort of tally
P192	Yeah and really not wanting it to end but ultimately it has to erm but yeah there is the whole timescale was a major factor for me.
NL193	Did it come in the room? Did *cllr* name how many sessions you had left?
P193	Yes oh yes she said that. At the end of each session she would say 'you've got x amount left now'
NL194	OK and would you say then being so aware of that, affected the work in any way from your perspective?
P194	Erm...*pause* not really I don't think. No.
NL195	OK I was just wondering when you said earlier about hating wasting time. I am wondering if that came in at all?
P195	Yes possibly. Hmm. Yeah! Actually...! Cos in my head although I had all these expectations maybe in my head I was reflecting that. Wanting to get as much out of this as possible so kind of use it wisely. Try to get as much out of...I was very vocal throughout. And even talking to you now I find that I am a completely different person and I feel like I can air what's inside a lot more than I can with certain friends.
NL196	Hmm
P196	I'm aware that I am much more animated with you and as I was with *cllr* than I am with certain work colleagues and certain friendships.
NL197	And what do you make of that?
P197	It's kind of confirmation for me that actually I'm not an idiot *laughs* do you know what I mean?! And it's good, it's a good feeling. In terms of self-realisation.
NL198	Hmm. Yes. *pause* **Has life changed for you for having had this counselling?**
P198	Erm yes it has. I'd be a fool to say that it hasn't. I do still get kind of static-y days where I am feeling, of nothingness and erm again at some weekends I do have tendency still to shut myself away. You know, no work, no distractions. Not allowing myself nice things basically. That's another thing that came up with *cllr* as well...she said 'you don't allow yourself any 'nice time'...you hang around with *laughs* horrible friends and you're not being very nice to yourself' so erm yeah I would be an idiot to say that it hasn't helped cos you know, the mere fact that I can talk to you the way that I am is saying to me that no I *have* changed.
NL199	Something has happened…?
P199	Something has happened definitely. Because in the first 2 session I remember being in that desperate state and almost scared of *cllr* in a way, not knowing, and almost apologising for me being there. But as the weeks progressed I became more and more animated and it was...it was a confidence building thing and maybe that was the relationship that was helping with that
NL202	Hmm. Would you use the service again?
P202	Yes I would and I would recommend it. I'm not just saying that, erm definitely and especially if you are going through any HIV related issues I think HCS is a good place to go

NL203	Thank you so much for your time. I'll stop recording and we can take a few moments to talk through how you're feeling...
P203	OK. Thank you so much, this has been really really interesting.